Rocky Mountain Medical Journal

New Mexico's Presidential Address

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INFANT FEEDING — INGUINAL HERNIA IN INFANTS
BENIGN LESIONS OF BREAST — DUODENO-COLIC FISTULA — PLACENTA ACCRETA
MONTANA INTERIM SESSION MINUTES — NEW MEXICO ANNUAL REPORTS

For Table of Contents, Turn the First Page


THE JOURNAL
American Medical Association
LA PRENSA MEDICA
ARGENTINA
NORDISK MEDICIN
THE LANCET
KLINISCHE WOCHENSCHRIFT
JOURNAL DE MEDECINE DE LYON
The Journal of Clinical Investigation
CALCUTTA MEDICAL JOURNAL
FELLOWS
TRANSACTIONS
OF
THE ROYAL SOCIETY OF TROPICAL MEDICINE AND HYGIENE
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Table of Contents

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Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

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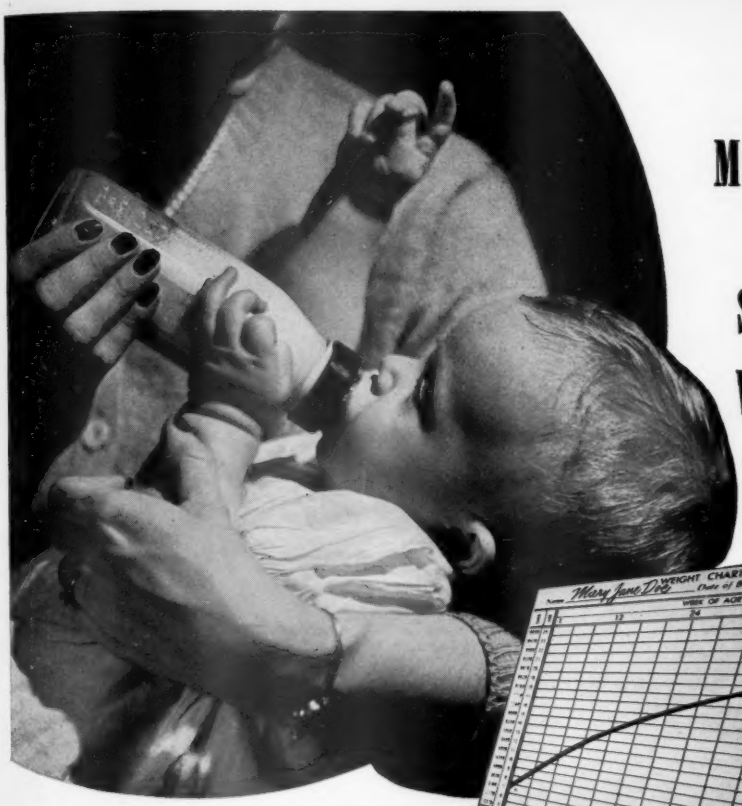

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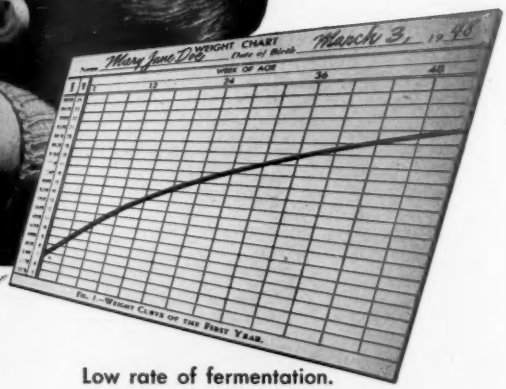

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NEXT ANNUAL SESSION: SHIRLEY-SAVOY HOTEL, DENVER, SEPTEMBER 18, 19, 20, 21, 1951.

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General Counsel: Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

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MONTANA MEDICAL ASSOCIATION

NEXT ANNUAL SESSION: GREAT FALLS, SEPTEMBER 13, 14, 15, 16, 1951.

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Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at 1951 Annual Session.

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Vice President: James M. Flinn, Helena.
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References:

1. Chidechel, M.: M. Rec., 158:736, 1943. 2. Gordon, E. S.: Nutrition and Vitamin Therapy in General Practice, Year Book Publishers, Chicago, 1947. 3. Krehl, W. A. and Cowgill, G. R.: Food Research, 15:179, 1950. 4. Moore, L. L. et al.: J. Home Econ., 37:200, 1945. 5. Rafsky, H. A. and Newman, B.: Am. J. M. Sc., 201:749, 1941. 6. Rafsky, H. A. and Newman, B.: Geriatrics, 2:101, 1947. 7. Roy, W. R. and Russell, H. L.: Food Industries, 20:1784, 1948. 8. Sadow, S. E.: M. Woman's J., 50:98, 1943. 9. Stephenson, W. et al.: Brit. M. J., 2:839, 1941. 10. Stieglitz, E. J.: J.A.M.A., 142:1070, 1950. 11. Thewlis, M. W.: The Care of the Aged, 3th ed., Mosby, 1946.

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Table I lists the amounts of sodium[3] in three kinds of meat. Table II gives the estimated amounts of sodium in hospital diets planned for cardiorenal vascular patients.[4]

SODIUM IN MEAT[3]

	Sodium Provided by 60 Gm. Serving	Sodium Provided by 100 Gm.
Beef, without bone	32 mg.	53 mg.
Lamb, without fat	66 mg.	110 mg.
Pork, without fat	35 mg.	58 mg.

Table I

SODIUM IN HOSPITAL DIETS[4]

Sodium-Poor Diets*				Very-Low-Sodium Diet†
40 Gm. Protein	70 Gm. Protein	100 Gm. Protein	130 Gm. Protein	70 Gm. Protein
400 mg. Na	500 mg. Na	800 mg. Na	1,000 mg. Na	200 mg. Na

Table II

*Foods prepared and served without salt.
†Weighed diet. May contain 4 oz. of unsalted meat.
(Normal diets contain approximately 4 Gm. of sodium daily.)

Hence, the data here shown indicate that relatively generous amounts of meat may be included in low-sodium diets.

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1. Wheeler, E. O.; Bridges, W. C., and White, P. D.: Diet Low in Salt (Sodium) in Congestive Heart Failure, J.A.M.A. 133:16 (Jan. 4) 1947.
2. Wohl, M. G., and Schneeberg, N. G.: Dietotherapy (Cardiovascular Disease), in Jolliffe, N.: Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, chap. 27.
3. Bills, C. E.; McDonald, T. C.; Niedermeier, W., and Schwartz, M. C.: Survey of the Sodium and Potassium Content of Foods and Waters by the Flame Photometer, Fed. Proc. 6:402 (Mar.) 1947.
4. Mayo Clinic Diet Manual, Philadelphia, W. B. Saunders Company, 1949, p. 113.

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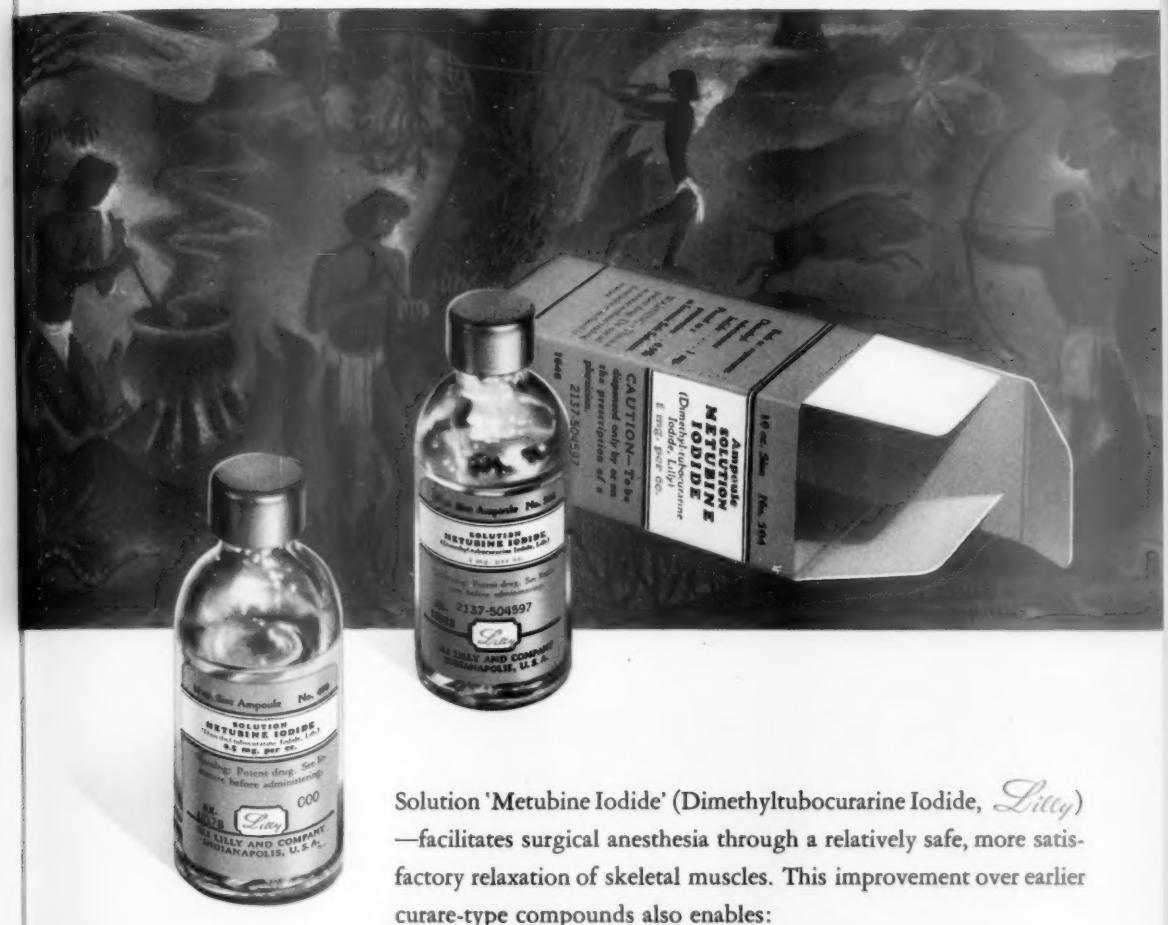

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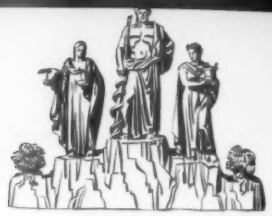

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Rocky Mountain Medical Journal
Colorado
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JUNE
1951

Editorial

The R. M. M. C. In Retrospect

WE MAY now look back upon the sixth biennial meeting of the Rocky Mountain Medical Conference and appraise the place which it has taken in the medical affairs of this region. One thousand persons registered at the Denver meeting last month, about half of them physicians who came from all our Rocky Mountain states, with scattered representatives of other nearby states. Residents and interns and medical students from the Denver area attended in goodly numbers. The 500 lay registrants included, in addition to our exhibitors and the families of some physicians, many technicians and members of allied professions interested in seeing the color television of medical and surgical procedures.

More doctors had been expected, and committees managing this meeting were disappointed in the slightly less than 500 M.D. registration. In retrospect we realize that our Conference was in competition with just too many other important meetings. This last May contained more medical meetings in this part of the United States than any other month within our recollection. New Mexico's Annual Session, the Ogden Surgical Society, the Aeromedical Association, the annual sessions of Nebraska, Kansas, Oklahoma—obviously a physician could have closed his office for May and still have been unable to attend all of these, for some of them actually overlapped!

Previous editorial comment regarding the multiplicity of medical meetings has been made in these columns. We believe there are far too many. Some physicians have had to give up attendance at any but a selected few, and, unfortunately, those selected are apt to be the ones with the most "social" and specialty appeal. This is not a healthy situation at the present time. Now, more than ever before, unification of medical activities is of vital importance.

A constructive step was taken by the Continuing Committee of the Rocky Mountain Medical Conference to simplify the relationship of the Conference to the activities of its member state societies. The Committee recommended that meetings of the Conference hereafter be rotated among the three states currently able to offer facilities for a meeting of its size, namely Colorado, Utah, and New Mexico, each of these states to be host in succession and the Conference to be held in conjunction with the host state's own annual session. Final adoption of the plan must await ratification by each of the five states, but the representatives of each state present at the Denver meeting endorsed the idea unanimously. It looks good to us. It should succeed, and should comprise an exemplary step toward simplification of medical society convention activities that have come to be a burden to some of our members.

The new rotating plan is, so far, just a proposal for the future. But the Continuing Committee used its existing authority over the next meeting to fix its place and approximate dates. It will be held in Salt Lake City in early September, 1953, in conjunction with the 1953 Annual Session of the Utah State Medical Association. Final dates will be fixed by the Utah Association.

The Denver Conference May 9-11 was

successful despite disappointment in its registration figures. The full-color television was probably the main attraction, and as a means of teaching, this method is superior. It is destined for a permanent place as such, even after the spectacular novelty wears off. Just now, it represents a tremendous undertaking, for which we are indebted to the Smith, Kline and French Laboratories. Quality of the general scientific program, exhibits both scientific and technical, and the entertainment at the stag party and at the banquet—all were at least the equal of any we have had. Permanence of the Conference is anticipated. We trust the innovation of combining it directly with its host state's annual session will be adopted and will prove a boon to all our regional activities.

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Pernicious Prognostications

PHYSICIANS and our institutions are often credited with more or less dramatic predictions of duration of life in hopeless cases. Occasionally the cases aren't so hopeless after all and some bizarre concoction, manipulation or other hokum gets credit for saving or prolonging life.

We made the headlines recently regarding a child said by our colleagues due to depart this earth by Valentine's Day. Public spirited people in the home town sponsored a trip to a "sanatarium" for nonmedical treatment. Reports handed to the lay press then told of the patient's improved weight, appetite, and brightness. Finally her vitality ebbed away and she "just plain died" after her benefactors had allegedly prolonged life to Easter time.

Such events appeal to the people's imagination, incite sympathy as well as curiosity. The history of this and similar cases reflects upon our judgment and humanitarian principles. Cultists, glorified in apparent contrast, feast upon our indiscretion.

Can't we remember that ours is not an exact science, and it is not for us or anyone else to state or imply that duration of life can be accurately prognosticated? It is tempting at times to pass up excellent opportunities for silence—and some of us hand out a few thousand dollars' worth of free advertising to "healers" who are more in the habit of paying for it.

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"Health Scheme Hits Young Doctors"

SUCH is the title of a recent article in the London City Press. It is especially interesting in view of Aneurin Bevan's resignation from the British cabinet—which probably has far deeper foundations than the supplying of "free" eyeglasses and false teeth. The following is quoted from the article:

> In recent weeks there has been a disturbing rise in the number of young doctors who are finding it almost impossible to secure appointments.
>
> Doctors are also finding it extremely difficult to obtain practices. A few practices are advertised each week by the Ministry of Health, but applications for each practice advertised number between 40 and 50.
>
> Under the National Health Scheme doctors are no longer able to buy practices.
>
> The Socialists held that the former system where a doctor had to buy a practice has excluded many young doctors unable to afford to do so.
>
> But now it is practically impossible to obtain a practice, and general practitioners are reluctant to take on assistants because, under the Health Scheme, if they do they suffer financially.

Apparently England is finding out a lot of things the hard way. It will be interesting to see what the next election indicates about the people's reaction to the Labor Government and all of its schemes.

Original Articles

BETTER PUBLIC RELATIONS THROUGH BETTER MEDICAL SERVICE

PRESIDENTIAL ADDRESS*

LELAND S. EVANS, M.D.
LAS CRUCES

Some two and one-half years ago, several members of the New Mexico Medical Society became quite concerned about the complete lack of any public relations program in the Society. Having read about the wonderful work being done by the Colorado State Medical Society in public relations, several members took advantage of an opportunity to visit the offices of the Colorado Society in March, 1949, to learn first-hand about the program that was being carried on by the doctors of Colorado. They came home inbued with the spirit of service exemplified there and with the determination to try to institute a workable program in public relations.

At the Annual Meeting in Roswell of that year a program similar to that of Colorado, but on a much smaller scale, was instituted. Under the chairmanship of Dr. C. Pardue Bunch great strides were made during the first year of this program and during the past year this program has gone forward with Dr. Earl L. Malone as Chairman.

Another factor which was most disturbing to many members was the inactivity of our committees each year prior to 1949. The reports of these committees would usually not require over thirty minutes of the time allotted for the meeting of the House of Delegates. Some committees often made no report at all. One could not sit in the House of Delegates Session this morning without realizing what strides have been made and the vast amount of work that has been accomplished by our various committees. This is most gratifying; however, there are some of us who feel that we are only "scratching the surface" in our public relations program.

None of us likes to be reminded of the fact that it was the threat of compulsory health insurance that really awakened us to our duties to our communities and to the state. About the time that our public relations program was started the American Medical Association was formulating plans for the National Education Campaign. The President of the American Medical Association that year was Dr. Ernest Irons. In a speech to rally the doctors behind the program of the American Medical Association he used the phrase, "Let us stand up and be counted." It is true that most of us have given strong support to the program of the American Medical Association. We were certainly willing to "stand up and be counted." However, it would seem that some of the doctors felt that after the counting was over they could sit down and go about their usual duties. Once more we want to try to have everyone stand up but this time, instead, we want to go to work and get our job accomplished. If each one of you will give the officers whom you have elected today—and the committees of this Society—your whole-hearted support whenever you are called upon to do a job by your county society officers or when you receive a call or letter from the state office, we can be justly proud of the work accomplished within the next year.

During the past five years the New Mexico Physicians Service has been striving, at times against very great odds, to make available to everyone in New Mexico a plan of voluntary health insurance to meet the needs of everyone in New Mexico. With the ever present threat of compulsory

*Delivered May 3, 1951, before the Sixty-ninth Annual Session, New Mexico Medical Society, Santa Fe.

health insurance it would seem that every member of our State Society would be eager to become a professional member of the New Mexico Physicians Service. Yet, there are several in our state today who are not members of this organization. If each member of the New Mexico Medical Society would devote just a part of the time that the President of the Board of Trustees, Dr. John F. Conway, has given to this cause, the New Mexico Physicians Service could realize goals that so far have only been dreams. As stated in a report by Dr. Conway today, a meeting was held last October between committees from the New Mexico Hospital Association and the New Mexico Physicians Service in an effort to work out a better understanding and to present to the public a unified program of prepayment insurance in medical and surgical contracts as well as hospital coverage. The joint committee had a most harmonious meeting; however, to date there has been no follow-up on the plans discussed at that meeting. It would seem most important that our efforts along this line be pursued until there is a definite working arrangement between the Hospital Association and the physicians of New Mexico.

Voluntary health insurance is no longer on a trial basis. The overwhelming response given to the advertising campaign of the American Medical Association last fall was proof that by far the majority of people prefer some form of voluntary health insurance to a compulsory health insurance program. In New Mexico our program has been handicapped due to the fact that we have not had many large groups, and due to our sparsely populated area. Let us continue to support our voluntary health insurance program whenever possible.

Time will not permit us to discuss all the activities of all our committees but a few deserve special mention. The committee on National Emergency Medical Service under the chairmanship of Dr. Anthony E. Reymont of Santa Fe has been active and during the past three years has tried to work out detailed plans pertaining to any disaster that might befall us. Let us hope that such plans will never have to be put into execution, but should it become necessary, we hope to be ready to meet any emergency that might arise.

The Rural Health Committee, under the able direction of Dr. Stuart W. Adler, has accomplished a great deal. Several communities which previously were without the services of a physician have been able to secure a doctor through the help of the committee on Rural Health and prospects are good that several other doctors will move into the communities that are in great need of them.

During the session of the New Mexico Legislature in 1949, several of us were chagrined to learn that the youngest county medical society in the state had sponsored a bill to repeal our Basic Science Act. It was not too difficult to have this repeal bill killed in 1949. Since that time it has been discussed with the House of Delegates on two different occasions. We have heard reports from members of our Basic Science Board and also the Basic Science Committee of this Society. The more that I study the effects of this law the more I am convinced that it should either be repealed or greatly modified. Of course, we will have to admit that fewer doctors of medicine fail to pass the board than other branches of the healing art and that a great many more doctors of medicine do pass, but are we gaining our proportionate number of doctors of medicine who graduate each year from the medical schools as compared to the osteopaths that enter New Mexico? As much as we like our fair state and proclaim its scenic beauties we will have to admit that it is possible that many doctors who live some distance from here and who are desirous of settling in the Southwest may not see these advantages as enough to offset the requirements of taking the Basic Science Examination.

Since we have no medical school in our state, great effort will have to be made to find some way to send our own premedical students to medical schools with some assurance that they will return to the state to practice. Almost one-half of the doctors in New Mexico are practicing

in Albuquerque and Santa Fe, where less than one-fourth of the total population is. If you will exclude Albuquerque and Santa Fe and possibly one or two other communities, you will readily admit that there is a great shortage of doctors in our state. Whereas the national average is one doctor for 850 people, in New Mexico the average is one doctor for 1,500 people. In some of our counties there is less than one doctor for 2,000 people, and, of course, there are still a few communities well able to support a doctor that have no doctor. Certainly, we cannot expect one doctor to take care of the needs of 2,000 people as well as one doctor can care for 1,000 people. It is my firm conviction that the acute shortage of physicians in the majority of New Mexico towns and counties is one of the basic causes for poor public relations. Therefore, only with adequate medical service will good public relations be established.

Dr. Harold S. Diehl, Dean of Medical Sciences at the University of Minnesota Medical School, has recently pointed out that if we want more rural doctors we will simply have to recruit more medical students from rural areas. Dr. Diehl's conclusions stem from a study of 545 Minnesota Medical School graduates. The study charted the graduates' present practice location in relation to the type of community in which they grew up. Three out of five medical students from rural areas later took up rural practice. Of the students from Minneapolis, St. Paul and Duluth, fewer than one out of four went to the country to practice. With the increasing need for more physicians in the military service our present need for doctors will be increased. Our efforts will probably have to be directed along legislative ways to find places for a sufficient number who desire to study medicine. A medical school for our state may not seem feasible at this time, but it may have to be considered in the future if other means are not available.

During the past year your Public Relations Committee has urged repeatedly that each county medical society provide for a central telephone exchange to help patients locate their doctor, or another doctor in case of emergency. In only a few instances has such a plan been started. Some of our strongest supporters are losing heart because too many doctors are still indifferent to this much needed service. Is it any wonder that so many people have confidence in healing art cults when some of our very best trained doctors do not see the need for making calls at unpleasant hours and are unwilling to take part in a system assuring everyone that a doctor will be available when needed? Let us make a great effort in the next few months to see that such a plan is provided for in every community.

It is gratifying to report the great strides in one phase of the public relations work and that is the Woman's Auxiliary of the New Mexico Medical Society. Under the leadership of Mrs. Carl Mulky, who has worked untiringly, several additional county auxiliaries have been organized and are now functioning. In the years to come we will receive valuable aid and assistance from the members of the Auxiliary.

One of the outstanding features of the public relations program during the past two years has been the active work done by the Board of Supervisors. Let us all continue to give the Board of Supervisors the support needed and to publicize the work done by this group of men. The service rendered to the physicians and to the patients by the Board of Supervisors is only one phase of better service to our patients that we must strive for continuously.

In December of last year the Board of Trustees of the American Medical Association donated $500,000.00 as a starting point for a voluntary fund to aid our medical schools. This fund has been growing steadily. Many of you have already contributed to this most worthy cause. Let us urge you to send in your donations to the American Medical Education Foundation if you have not already done so.

Finally, as a service to our state, let us not forget the important part that we doctors, individually, can take in matters of politics which affect all of us greatly. For

those of you who might doubt this, let us remind you of what happened in Florida last summer and Colorado last fall. Let us make our plans to take an active part in the campaign next year as individual citizens.

In conclusion, let us remind you how you may render another valuable service. When someone asks you questions pertaining to our profession, take a little time and explain things to them in detail, especially if you should be asked why we feel that members of hospital staffs should be limited to qualified ethical members of our own Society. After all, there are vast differences in training!

SO-CALLED "PROGRESS" IN INFANT FEEDING*

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Those of us who learned the physiology of digestion first, particularly in infants, have been amazed at the changes in infant feeding during the past twenty-five years. To paraphrase the advertising slogan, "Progress Means Change," change does not always denote progress. This statement is emphasized because it is probably advertising, not scientific research, which is responsible for the so-called "modernization." To answer the anticipated charge of "old-fashioned and behind the times," the physiologic facts of digestion in infancy have not been modernized nor changed.

Nature produced breast milk in the mother to feed the infant for the greater part of the first year. The first teeth do not erupt before six or seven months because nature did not anticipate any need for them. Ptyalin does not appear in the saliva in appreciable amount before the third or fourth month of life. The infant does not learn to use his tongue and jaws to attempt to chew and mix and swallow solid foods before he is three and one-half or four months of age. The intestinal tract is unable to filter out large protein molecules from the food before the child is six or eight months of age. The baby's blood sugar level is most variable during the first year of life. It is extremely susceptible to the amount of sugar digested. The newborn baby empties his stomach in three hours if he is on breast milk and in four hours on cow's milk. Nature intended him to take a certain amount when he is hungry and not to exceed his capacity which was expected to last him three or four hours. These are all physiologic facts which may be verified in any standard textbook on physiology.

While there is no doubt that many laws of nature may be violated with impunity, the penalty may eventually be exacted at the expense of the innocent victim. There have been an endless number of various food modifications for infant feeding. None has ever surpassed or even equaled breast milk as produced by nature. The best substitute for breast milk is a properly prepared cow's milk modified to the approximate composition of human breast milk. While it is true that the newborn infant may be able to tolerate undiluted cow's milk and may live without the addition of carbohydrate, there is no justification in submitting the infant to such a hazardous insult or test of his digestive capacity. The digestive tract of the newborn infant is always operating at near capacity under normal conditions. For that reason, the additional load of a fever, infection, excitement, or injury usually exceeds the digestive capacity and the infant vomits or develops diarrhea, or both. While most well infants have tolerated insults to their digestive organs, it takes a long time before the human individual can tolerate or enjoy martinis and cocktail parties. The average well fed healthy infant will thrive best on breast milk or an approximate modification of cow's milk, preferably evaporated, which should be offered to him every four hours, six times in twenty-four

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hours, according to his appetite and capacity, for the first two months of life. Such an infant will double his birth weight in four months which is all that should be expected. While it is possible to stuff infants like geese or hogs, there is no point in the procedure and the objective is not the same. Cereals are not needed, nor well digested, nor well tolerated before the third or fourth month of life. As stated above, there is not enough ptyalin or starch digesting enzyme present in the saliva of the infant to handle cereals properly nor is there an ability to chew properly or masticate or handle solid foods. The additional danger of the early addition of foreign proteins, that is of any food besides milk, to the diet of the infant is the danger of sensitization of that infant to some of the protein products. I believe that it is the early introduction of unnecessary and indigestible foods which is responsible for the great increase in chronic intestinal indigestion and in some of the allergic diseases during the past twenty-five years.

In certain cases of pyloric obstruction, thick cereal feedings have been of value when given as early as two weeks of age. In certain other conditions such as pancreatic insufficiency, bananas have been well tolerated and have been of value. However, these foods are used as emergency measures and not as routine. It is possible to drive your car 100 miles an hour or more, but the procedure is not safe. Vegetables, bananas, and other fruits may safely be added to the infant's diet at five or six months. No one has ever demonstrated any need for these food supplements at an earlier age. Hard boiled eggs, strained or chopped meats may be added at six months or later. Broth, gelatin, and custards may be added at the same time. It is highly desirable to add one food at a time and to wait four or five days before additions to determine the reaction and tolerance of the infant. There are unlimited varieties of canned or processed infant foods packed by reliable and responsible manufacturers. These provide a great convenience to the modern mother. The only danger lies in the persistence of the detail salesman who is able to persuade or convince the young physician who may mistake notoriety or popularity for recognition and success. The can opener should not replace the eye opener. Mothers should determine the needs and quality of a preparation before feeding it to their children. The competition between parents (for their infants) should not be carried to gastronomic achievements in their offspring. While it is possible to put a very young infant on three meals a day, it is most unreasonable to first overload his stomach with an extra one-third of his twenty-four hour requirement and then let him suffer later while his blood sugar level goes down below normal awaiting the next delayed allowance of food. If there is to be a competition between mothers for records in digestive tolerance let them use geese or hogs and spare the infants.

Millions of dollars are wasted on vitamins every year. There is no doubt that the average infant can use and utilize additional vitamins A and D to prevent rickets and additional vitamin C or ascorbic acid to replace citrus fruits in the early months of life. Beyond that the multiple vitamin preparations are an unnecessary luxury inflicted upon us by modern advertising. The objective of modern infant feeding ought to be healthy, well, strong babies and children who learn to eat to live without indigestion and not live to eat. Common sense is still the method of choice in infant feeding as in infant care. No infant or child should be forced to eat when he is not hungry nor required to wait long when he is. The so-called "self-demand" schedule has some merit but it is not new nor modern. Long before infant feeding became a specialty, mothers carried their infants with them and fed them when they cried or acted hungry. There are still primitive peoples who do the same. However, no mother can distinguish the cry of hunger from pain or discomfort. Therefore, many infants are overfed. An infant in discomfort, even with the colic of a distended stomach, will usually accept more food and will stop crying if a nipple is put

into his mouth. However, most infants if given a chance will establish a fairly regular three or four hour schedule. Most mothers have much more to do than feed the baby, and, therefore, find it necessary to adopt and follow a regular schedule in their home work. Thus the march of civilization has forced us to accept regularity and schedule in our adjustment to society. The infant must do the same. However, his physiologic mechanism should be satisfied and not abused.

BENIGN LESIONS OF THE BREAST*

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For a number of years cancer of the breast has remained one of the commonest of cancers. In spite of our efforts to be optimistic about this disease, based on the fact that an encouragingly large number of women have been cured by adequate surgical attention, we are constantly conscious of the fact that many more have died of the disease. Furthermore, many of these deaths have been most miserable. Since there is hardly a woman who has not had some friend or relative die of cancer of the breast, the implications of any breast abnormality at the present time are such as to cause the patient great concern. She frequently seeks aid from her physician in consternation. This situation is worsened by the frequency of breast abnormalities and by the importance that the breast plays in the normal psychic adjustment of most women. Often she becomes frightened at the slightest disability and confronts her physician with at times insignificant disturbances. Every consultation poses for us not only a diagnostic problem but also a considerable psychologic problem.

There was once a surgical dictum that advised us when we were in doubt as to the nature of a breast lesion we should do a radical removal of that breast, but the breast cannot be removed with the same casual insouciance with which tonsils have been taken in times past. When the patient presents herself with the rarely expressed but always implied question, "Do I have a cancer?" a dilemma is in the making.

Although excision of the breast is mutilating, a biopsy of the breast need not be. Recognizing that delayed and inadequate surgery may do great harm if the lesion were to be malignant, always when the surgeon is confronted with a mass in the breast, the nature of which he does not know, he must immediately find out and do so in an aggressive fashion. This can always be done by gross and microscopic inspection of the lesion after it has been removed. If the surgeon does not have the pathologic ability to make such a distinction, and today there is no reason why he should not possess this ability, there is hardly a hospital in this country where adequate pathologic consultation is not available. If this consultation is not available immediately, it can be obtained without too much delay. Therefore, I think it is safe to state that it is inexcusable for a diagnosis of a questionable lesion in the breast to be established by the process of observation and time. Of all of the methods of differential diagnosis available to us today, this is by far the most unsatisfactory and the most dangerous.

If the lesion proves to be benign, either by physical examination or by biopsy, our patient now has another implied question rarely asked us but one that we must always try to answer. "Will it ever become malignant?" No one can answer this question with dogmatism. In such a situation when a clear-cut answer is not possible, it becomes necessary for us to sit down with our patient and explain to her the exact nature of her process. This requires a knowledge of what might be termed the biology of the mammary gland. This shall

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be the subject of my discussion in this paper.

My thesis will be a simple one. It is dependent upon the fact that the development and the basic structure of the breast are dependent upon the action of certain hormones acting upon breast tissue and that structural malformations in the breast of a benign sort are a result of a disparagement in the relative reaction of these hormones in the breast as related to normal secretion and normal structure. Thus, the entire story of benign lesions of the breast will represent not a group of different diseases such as is generally described in most monographs on the subject but a continuum dependent upon the reaction over a long period of time of certain structures to certain stimuli. One might consider then the pathology of the breast as a type of pathology in the fourth dimension because it is affected by time. The lesion which a girl will show in the late teens or early twenties may change completely in the thirties and even more in the later thirties or early forties. The breast then is not a static viscus. It is extremely dynamic in its structure, and your patient will have a different picture at different periods of her life. Such a treatment of breast lesions as a continuum of morphologic change rather than a series of unrelated lesions cannot be undertaken adequately unless we first review briefly the normal changes in breast development and the stimulations which brings this change about.

The three hormones most important in their action upon the mammary gland are the estrogens, progestin, and prolactin. The estrogens have their origin chiefly in the ovary, although the adrenal cortex, the placenta, and in the male the testis are rich sources of estrogenic supply. Progestin is derived chiefly from the corpus luteum. However, because of the chemical resemblance of some of the androgens these latter substances may mimic to a lesser degree the corpus luteal action on the breast. Prolactin, which is secreted by the anterior lobe of the hypophysis, has as its function the stimulation of milk secretion and need not concern us in this discussion. Of secondary effect would be the gonadotropic hormones of the hypophysis and some of the androgenic sterids from the adrenal cortex. In discussing the action of these various hormones a certain amount of oversimplification will be necesarry as there is considerable variation in different species. By far the most important is the action of the estrogens.

Estrogens, for instance, seem to be responsible for the development of the nipples. Male mice, as is known, normally do not have nipples but these will develop under the influence of estrogen treatment. Estrogens probably are responsible for enlargement of the nipple during various periods of life. Pigmentation of the areola appears to be the result of estrogen action. It seems to be definitely related to an increase in the permeability of the capillaries in this area. The most important estrogenic effects which will concern us have to do with the action on the breast parenchyma, chiefly of the duct system. When estrogens are administered, there results a proliferation and a ramification of ducts with dilatation of the lumen, an increase in periductal fibrous tissue, an increase in periductal edema, leucocytic infiltration, and in some species the development of acini.

The main effect of progesterone has to do with the development and maturation of the acini and alveolar lobules in the breast. This action will not take place unless there is an adequate previous effect from the estrogens. Interestingly enough, larger doses of progesterone tend to limit the estrogenic action on the breast. In women under normal conditions in all probability the acini never completely disappear between ovulatory cycles, although considerable regression may occur at the time the menstrual flow begins.

I think we would make a mistake were we to think that all breast tissue is affected equally and simultaneously by either of these two secretory agents. Furthermore, we must remember that while to a large extent these two agents, namely estrogens and progesterone, are physiologic antagonists insofar as the ductal system of the breast is concerned, they do not appear

in the body at exactly the same time in life, nor do they cease their appearance at the same time. Since the appearance of progesterone depends upon the formation of the corpus luteum and that in turn is the result of maturation of the graafian follicle, it can be readily anticipated that the most common defection that we shall find will be an inadequacy of progesterone effect. This is due to the fact that progesterone secretion begins later and ceases earlier than does that of estrogen. It also is notable that there are many women who do not have regular monthly ovulatory cycles.

That the lack of ovulation and thus corpus lutem formation might play a part in forming an imbalance in ovarian hormonal secretion is suggested by a review of some of our patients a few years ago at the Barnes Hospital in Saint Louis, by Smith. We felt that if there were a relative estrogen hypersecretion it might be explained by the infrequency of ovulation and, therefore, studied the frequency of pregnancy in women with benign lesions of the breast as compared to the statistical occurrence in normal women of this region. It is interesting to note that pregnancy was approximately one-half as common in women who have benign lesions of the breast as in normal individuals of that age period. Where pregnancy did occur, we found that it generally was limited to one or at the most two children and rarely three. Again, suggested evidence along this line is offered in a study that is now going on in collaboration with Doctor Keettel in our Department of Obstetrics and Gynecology on the uterine endometrium in patients with benign lesions of the breast. In a fairly large series of patients now, we have noted almost universally a failure of evidence of progesterone action on the structure of the endometrial cells. Still additional evidence is offered in the human by biopsies which have been made on the male breast in patients with carcinoma of the prostate gland who have received large doses of estrogen over a long period of time. Serial biopsies have been performed in some of these individuals, and almost every type of benign lesion has been observed with the exception of the discreet juvenile fibroadenoma.

Realizing then the structural changes which result from such hormonal overbalance and realizing the effect of time and age, it becomes possible for us to reconstruct fairly readily the abnormal chain of events with which we so often are confronted by our patients. Usually the earliest situation in terms of age which confronts us is the young girl of eight or nine years who is brought in because her mother has noted a small tender buttonlike mass beneath one of the areolae. The child has not yet begun to menstruate. Were such a lesion to be studied microscopically, and it should never be so studied, one would see extensive ductal proliferation with periductal edema and leucocytic infiltration. This is an example of one breast being sensitive to the action of estrogen, while the other is not. Usually the other breast catches up within the next year or two and the mother can be informed that the situation is of no significance.

A counterpart of this situation is seen in boys at about the age of 14 to 18 years, that is during puberty. It is due to the fact that the testis also is a great source of estrogen secretion, perhaps as great as the ovary. Normally this estrogen secretion on the part of the testis is counterbalanced by androgen secretion on the part of the interstitial cells. There are times, however, in the adjustments of increased secretions during puberty when the amount of estrogen produced by the testis outweighs the amount of testosterone which ordinarily would counteract it physiologically. The result is a small enlargement of the breast tissue beneath the areola similar to that described in the young girl. This enlargement usually is very tender and in this instance very embarrassing. Again, this lesion never does harm. It is not a precancerous lesion and really is not gynecomastia. Here also the physician can promise his patient that if the lesion is left alone everything will soon be all right. One can hasten this process by giving male sex hor-

mone in the form of methyl testosterone or testosterone propionate. It is important that this lesion be differentiated from the true gynecomastia of a more massive type that one sees rarely, associated with adrenocortical tumors or tumors of the testes.

When evidence of such ductal overgrowth occurs later in life, and in particular beyond the age of sixty as it not infrequently does, excision generally is advisable. Here the patient is in the cancer age and the development of an adequate duct system may make the subsequent presence of cancer of the breast possible. Certainly we have noted it in two patients with carcinoma of the male breast in which gynecomastia had appeared after the age of forty and had persisted for a long period of time.

One of the early and common manifestations of morphologic alteration in the female breast that is the result of an abnormal response to chemical stimulus is the so-called fibroadenoma. While it is difficult to produce such a lesion in many experimental animals, enough evidence is present to suggest that this is a result of hormonal action rather than a true neoplasm. Why this small area of breast tissue should react differently to the estrogens than the remainder of the breast parenchyma is still not known. When examined microscopically, one sees ducts that are dividing profusely and that are markedly dilated. Often the lining epithelium is hyperplastic. There is a tremendous amount of edema around the ducts, and where such edema is extensive the term, adenomyxoma, has been used. Such edema probably is due to retention of fluid very much as one sees in the endometrium and may be related to changes in capillary permeability such as is seen around the areola and in the endometrium. Such edema, if it exists for any particular length of time, is associated with extensive fibroplasia. This naturally creates a need for more space, and as it does it presses into the normal breast tissue and forms an adventitious capsule. It is within the breast tissue so that it can be moved around as one would a small hickory nut.

When an adenofibroma occurs in the early twenties, one sees less edema. More commonly there are multiple encapsulations with beginning dilatation of the ducts and intracanalicular development. When it occurs even later, there is even less tendency toward isolation of the process. The fibroplasia shows thick collagen formation and less edema. The ducts become tremendous and the fibroplastic proliferation enfolds into the ducts, giving the striking appearance of intracanalicular fibrodenoma.

The gross appearance of the lesion becomes obvious from its microscopic structure. The expanding focal growth has formed a capsule under a great deal of tension. It has been a slow expanding lesion and, therefore, when the capsule is sectioned the tumor overflows. Because of the large ducts, if one spreads any part of the tumor it splits. It is a lesion so completely characteristic that there hardly is the need for microscopic confirmation in making a diagnosis.

If the fibroadenoma is left undisturbed, its course usually is fairly characteristic. After a period of several years, it gradually begins to decrease in size, becomes much harder, and may even form calcium salts in the stroma. There are two exceptions to this usual course of events. One is fairly common and is seen during the course of pregnancy. Occasionally these lesions become quite sensitive to the action of the estrogen-progesterone secretion of pregnancy and become quite large. They also show a tendency to involute much more slowly following the cessation of pregnancy than does the remainder of the breast tissue. Interestingly enough, I have never seen lactation occur in a fibroadenoma.

A much rarer complication of the fibroadenoma is the development of sarcomatous change of the stroma. The picture is one of a cellular, edematous sarcomatous stroma composed of young fibroblasts and surrounding numerous ducts which apparently do not take part in the process. For this reason it has been called an adenosarcoma by some. While it gives a better

prognosis than fibrosarcoma in general, it should be considered a definitely malignant tumor. At one time I felt that the simple excision of the lesion in the breast was adequate treatment, but more recently I have encountered three patients with axillary node metastases. I now feel that in the so-called adenosarcoma, or cystosarcoma phylloides as it also is termed, it must be treated with radical excision of the breast. The diagnosis never is very difficult. The lesions sometimes are as large as an orange; they never are small. As a rule, there is a history of a long-standing fibroadenoma which recently has increased in size. It is safe to say that the fibroadenoma should be removed as it is potentially dangerous and is simple to remove.

When periductal fibrosis occurs during the third and fourth decades of life, it usually is less isolated and more diffuse although at times it may be more or less confined to a single quadrant of breast tissue. Also, usually at this time one can note a beginning dilatation of the ducts resembling small cysts on cut section. An examination of the epithelium of these ducts or cysts shows that at times it resembles that of a sudoriferous sweat gland. As this appears there also is usually noted atrophy of the acini and the so-called lobule system. There becomes less and less evidence of the action of progesterone. With each menstrual cycle these findings become exaggerated. Because of the tension around the ducts attempted enlargement frequently is associated with considerable pain and tenderness. This usually is exaggerated shortly before the menstrual period. Examination of the breast at such a time demonstrates what appears to be a fine nodular extension along the major ducts, often in a single area but at times throughout both breasts. These small nodules represent the cystic dilatation and periductal fibrosis and range in size from 1 to 2 mm. in diameter. There is little that can be done for them. The pain often is helped by the administration of progesterone, or at times testoserone. Such painful breasts represent one of the common complaints. When the patient is reassured that there is no evidence of cancer and an adequate uplift type of brassiere is supplied her, she generally does not demand the more extensive hormone therapy.

Usually ovulation has ceased in most women during the latter part of the fourth and early part of the fifth decades. Menstrual activity, however, continues often for ten more years, and there thus appears a marked preponderance in estrogen secretion. Previously small cysts may suddenly take on marked increase in size, giving the so-called blue dome cysts. These may become several centimeters in diameter. The cysts generally contains clear fluid and microscopically the epithelium, as a rule, is flat. Many of them are lined by the epithelium of the previously described sweat gland type, and rare indeed is it to find evidence of acinar formation in such a breast. Duct dilatation of various diameters, however, are encountered; and where involution has been rapid, areas of lymphocytic infiltration may be noted.

Since we feel that these various forms of chronic cystic mastitis which have been delineated are the result of estrogen overbalance, one can rightfully ask us, "Do estrogens produce cancer of the breast?" Two decades ago that answer would have been easy, but today there is much less evidence that such is the case. It is quite possible that the chief part which these substances play in the production of cancer of the breast is in the providing of a duct system on which certain other factors may act to develop such a cancer. Certainly the injection of estrogens into strains of animals not susceptible to cancer of the breast does not result in cancer of the breast, although it may tend to hasten the development of cancer in those strains of mice susceptible to mammary carcinoma.

If we look upon the lesion of chronic cystic mastitis then as a morphologic aberration resulting from abnormal hormonal response, we see our cysts as dilated ducts, our adenomas as multiple branching of these ducts, and our fibroadenomas as periductal fibrosis and edema. We can easily understand why surgical excision of a small area of such breast tissue becomes a diag-

nostic procedure rather than a therapeutic procedure.

Does this morphologic distortion tend to eventuate into cancer? Unless there is considerable overgrowth present, the evidence certainly is not impressive either when considered from a statistical standpoint or from a biologic approach. When epithelial proliferation along the ducts and their cystic dilatations occur, a hazardous situation does exist. Abnormal epithelial proliferation remains benign only so long as it is contained within certain barriers. Such a proliferation presents itself in chronic cystic mastitis, in the larger ducts as ductal papillomas, in the cysts as intracystic papillomas, and in the terminal ducts as Schimmelbusch's disease. Fundamentally they are the same lesion, varying in appearance as the result of their site of origin.

These lesions often are not palpable in their early stage. The most common consistent finding which they produce is discharge from the nipple, either of a bloody or of a serous plasma-like type. This type of discharge obviously represents ulceration in the duct system and thereby differs from the discharge seen in the more common cystic lesions where it is of a stagnation type, being composed of turbid lipid material.

In a recent study of our experience at the University of Iowa Hospitals Donnelly has shown that where a patient with such a bloody discharge was observed over a sufficient length of time, the maximum being twenty years, there was approximately a 50 per cent chance of cancer developing in one or the other breast. He noted further that those patients who were treated by local excision of the area from which the bleeding apparently arose often subsequently developed cancer. Simple excision of the breast represented by far the most effective treatment. At the time of admission to the hospital 7 per cent of patients with a bloody discharge had small duct proliferation, 31 per cent had duct papillomas, and 32 per cent had ductal carcinoma. The remainder had frank cancer of varying types.

Bleeding from the nipple in the absence of cancer, therefore, is a dangerous sign, and one is in a safer position to recommend simple mastectomy regardless of whether or not a mass is palpable. This does not mean that such a mastectomy must be urged at once. This is a mutilating procedure and often mitigating situations will make it advisable to delay such an operation perhaps for some years. Such patients, however, should be kept under the most careful scrutiny in order that the very earliest malignant change might be detected.

In conclusion, it seems to me an impossibility for a surgeon to approach the problem of lesions of the breast adequately if he does not have a clear understanding of the underlying biology. To remove the breast lesion, to send it to a pathologist, and to rely entirely upon a single diagnostic term which that pathologist returns is grossly inadequate. Here above all places the surgeon must be his own pathologist for it is impossible to communicate by diagnostic terms the actual appearance of many of these lesions; and unless the surgeon does know what it looks like, he cannot give the proper care or the proper advice. Only in so doing will it be possible for him to be conservative when conservative measures are justified and radical when radical measures are indicated.

ROCKY MOUNTAIN CANCER CONFERENCE PROGRAMS MAILED

Preliminary programs for the Rocky Mountain Cancer Conference, to be held in Denver July 11 and 12, 1951, were mailed in late May to physicians of the Rocky Mountain and adjoining states. Material mailed with the programs urged all interested physicians to make hotel reservations well in advance, bearing in mind that mid-July is also in the midst of the tourist season.

Guest speakers for this fifth annual meeting of the Conference will include Oscar T. Clagett, Surgeon, of Rochester, Minn.; W. Edward Chamberlain, Radiologist, Philadelphia; Robert A. Scarborough. Proctologist, San Francisco; John Rock, Gynecologist, Boston; G. Edmund Haggart, Orthopedic Surgeon, Boston; John H. Lamb, Dermatologist, Oklahoma City; Frank B. Queen, Pathologist, of Portland, Oregon, and Walter L. Palmer, Chicago, Gastroenterologist.

The program includes a banquet to which ladies are also invited, the evening of July 11, and other entertainment.

THE SURGICAL REPAIR OF INGUINAL HERNIA IN INFANTS AND CHILDREN*

H. CALVIN FISHER, M.D.
DENVER

The repair of an inguinal hernia in infants and children is one of the most satisfactory surgical procedures of childhood. Confusion, however, arises as to the proper treatment, as a result of the usual spontaneous obliteration of the processing vaginalis during the first year of life, and because of the difference of opinion as to the proper age for repair and the type of truss, if any, to be worn. Once the diagnosis of inguinal hernia is made, surgical repair should be done.

Diagnosis

The hernia may be evident at birth or may not appear for weeks, months, or years later. It may be provoked by straining due to crying, constipation, or phimosis. The diagnosis can be made definitely only if the hernia is observed while "down" in the inguinal canal or scrotum.

Palpation of the external ring by invagination of the scrotum is unsatisfactory in children. Thickening of the cord at the point of exit at the external ring is significant. The cord structures here lie subcutaneously and are therefore easily palpated. Thickening of these structures plus a typical history of inguinal bulging as described by the mother is strong presumptive evidence for the presence of an inguinal hernia.

The diagnosis is difficult in the presence of an irreducible swelling of the cord or scrotum. Transillumination is of little aid. Hydrocoele is the condition most commonly confused with an incarcerated hernia.

Course

Twenty-five per cent of all male children have a patent processus vaginalis at birth. It has been estimated that 50 to 95 per cent of these close spontaneously or with the aid of a truss. The weakness, however, persists and a true hernia may develop later. Many scrotal herniae of the so-called congenital type appear presumably for the first time in adolesence or early adult life. Some of these undoubtedly result from the re-establishment or persistence of patency of the processus vaginalis of infancy and repair during early life would have cured the condition.

The contents of the sac in male children is usually small bowel as large intestine rarely occurs in scrotal hernias in children and omentum, the most common content of hernias in adults, is seldom sufficiently developed to reach the scrotum.

In female infants the tube and ovary frequently are present as contents of a hernia. Five cases in this series were complicated by incarceration of the ovary within the sac. One of these was gangrenous and required resection. This was the only instance of resection of any organ within the entire series.

Incarceration occurs in 5 to 7 per cent of all cases. The majority of these are in the very young (Figs. 1 and 2). Strangulation has been reported rarely in the recent literature. Barrington-Ward, however, in 1928 stated that strangulation was by no means uncommon in infants 3 to 6 years of age. Earlier operation on infants may be responsible for the change.

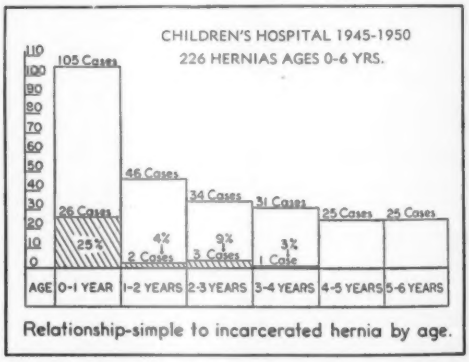

Fig. 1. This group includes only hernias of children under 6 years of age. Note the high incidence of incarcerated hernias (shaded groups) in the first year.

*From the Surgical Service, Children's Hospital, Denver, Colo.

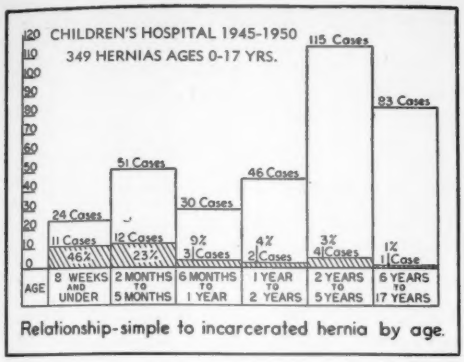

Fig. 2. Arbitrary age grouping. Note 46 per cent incarcerated hernias of infants under 8 weeks of age. Incarcerated hernia represented by shaded group.

Treatment

The preferred treatment is surgical repair of the hernia. The operation is simple and yields uniformly good results. The anxiety of the parents is relieved. The length and cost of hospitalization is less in infants than in adults. The infant may safely be discharged from the hospital in a few hours or a few days after operation. Recurrence is rare and when it does occur it is the result of a technical error. There should be no mortality.

Without operation the persistence of the hernia into later life may occur even though the clinical disappearance of the hernia is presumably accomplished. Hogg reported four infants with hernia at birth. These disappeared spontaneously only to reappear at the ages of 1, 5, 6 and 7 years.

Operation

The technic of repair of an inguinal hernia in infants consists of (1) a short tranverse incision, 2 inches in length being adequate; (2) the external oblique should be divided for a distance of 1½ inches in order to expose the base of the sac; (3) the sac is carefully isolated without disturbing the other cord structures; (4) a high ligation of the sac is secured with at least one transfixion suture; (5) the cord should not be transplanted under the age of 10 years; (6) the wound is closed in layers with cotton or fine silk.

Children should be operated at any age they present themselves—this, of course, providing there are no complicating conditions. Such contraindications are respiratory infection, nutritional disorder or excessively hot weather. A yarn truss may be used in such a situation until the patient is tided over the complications.

Children's Hospital Series

From January, 1945, to January, 1950, 349 inguinal hernias were repaired at Children's Hospital, Denver, without mortality; 305 of these were males and forty-four were females. Two males had femoral hernias in addition to the inguinal hernias.

There were thirty-six associated hydrocoeles in males and one hydrocoele of the canal of Nuck in a female (Fig. 3). Nine incidental appendectomies were performed without complication. One of these appendices was acutely inflamed. There were thirty-three instances of incarceration. One gangrenous ovary was resected.

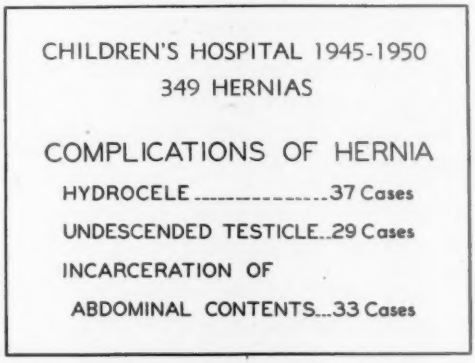

Fig. 3. Total complications of inguinal hernia. Note incidence of incarceration of almost 10 per cent of the total group.

The operations were performed by forty-three surgeons. Two of the hernias were recurrent hernias. One of these had been previously operated at Children's Hospital and the recurrence was due to a technical error—inadequate closure of the sac. There were five grossly infected wounds in the series.

Summary

Three hundred and forty-nine inguinal hernias were repaired without mortality. Only two of these were recurrent hernias. One resection of a gangrenous ovary repre-

sented the only resection in the series. The high incidence of incarceration in the first year of life is emphasized with very low occurrence between 6 and 17 years of age.

The low recurrence rate, mortality rate, and relative hospital costs are emphasized as points recommending the early repair of hernias. Many of the hernias of adult life begin as untreated hernias in infancy and childhood.

Neglected incarcerated hernias in the first year of life will often result in strangulation. Female infants with incarcerated abdominal organs should be operated upon particularly, because of the frequent presence of ovary and tube within the sac.

Case Reports

DUODENO-COLIC FISTULA

J. G. GARLAND, M.D., and
KON WYATT, JR., M.D.,*
MILWAUKEE, WISCONSIN

Isolated reports of occurrence of duodeno-colic fistula appearing in the literature indicate it is a rare phenomenon. Two distinct causes have been observed—neoplastic and inflammatory. The former is due to carcinoma of the colon with extension into the duodenum. The latter is due to a preceding inflammatory phase, causing a fistulous communication between the duodenum and the colon following perforation of a duodenal ulcer, a gallstone, ulcerative colitis, or caseating tuberculous lymph nodes.

Most duodeno-colic fistulae are neoplastic in origin and even these are rare, as pointed out by Drake and Saleh. Only five cases of benign inflammatory duodeno-colic fistulae have been recorded between 1885 and 1950, according to Ogilvie. He added two cases, and Railton reported one more.

CASE REPORTS

Case 1. R. H., a 45-year-old white male, was first seen April 9, 1949, complaining of abdominal pain and diarrhea of five weeks' duration and loss of twenty-two pounds in the previous six months. He felt good until six months before entrance. Anorexia and epigastric bloating not related to food have been present since. There was some relief from soda. There was no melena. The abdomen felt normal. Upper gastrointestinal x-ray studies revealed a duodeno-colic fistula between the second portion of the duodenum and the proximal transverse colon. This was also demonstrated by a barium enema x-ray study. There was no x-ray evidence of malignancy. The patient was prepared for surgery with a presumptive diagnosis of ruptured duodenal ulcer with perforation into the proximal transverse colon. At operation an indurated mass 4 by 3 by 2 inches was found involving the midportion of the ascending colon and the duodenum. Its serosa contained small gray nodules. Several hard enlarged lymph nodes were felt in the mesentery along the right colic artery. One of these nodules was removed and quick-section miscroscopic examination revealed adenocarcinoma. The terminal ileum, the ascending colon, the right half of the transverse colon, with the mesentery to the superior mesenteric vessels, and the involved segment of duodenum were resected en masse. An ileotransverse colostomy and a duodeno-jejunostomy (one-half inch below the Sphincter of Oddi) were done, and the proximal end of the distal stump of the duodenum was closed. The removed specimen revealed an adenocarcinoma encircling the entire lumen of the lower right colon that had an ulcer two and one-half inches in diameter posteriorly. The deep portion of the ulcer lay within the lumen of the duodenum. Surrounding fat and regional lymph nodes showed malignant infiltration. The post-operative condition was good until the third day, when bile drainage was present at the drain site. The patient expired on the sixth post-operative day and autopsy disclosed a peritonitis due to a partial separation of the duodenojejunal anastomosis on the posterior-medial aspect. The common bile duct was intact.

Case 2. M. S., a 50-year-old housewife, was first seen on July 30, 1949, complaining of severe pain in the epigastrium and vomiting of twenty-four hours' duration. She had a history of qualitative food dyspepsia and a mild episode of similar pain six years previously. There was rigidity and marked tenderness in the epigastrium and right upper quadrant, but no jaundice. The leukocyte count was 14,400 with a shift to the left. The serum amylase was normal. Abdominal x-ray scout film revealed a calculus in the region of the common duct. A diagnosis was made of acute pancreatitis with chronic cholecystitis and lithiasis. Conservative therapy was followed for three days with daily improvement. Starvation seemed to decrease the clinical signs of pancreatitis as pointed out by Luim and Maddock. Her condition suddenly became worse and she was taken to surgery. Operation revealed marked fat necrosis of an edematous omentum, a gallbladder full of stones densely bound down by old adhesions, and a 3 by 2 inches bluish bulbous mass under the gastrocolic ligament attached to a pancreas that was enlarged three times normal size. The choledochus was not dilated nor thickened, and no stones could be palpated there. The common duct was not explored. A cholecystostomy was done, the stones removed, and a rubber tube sutured in. The pseudocyst of the pancreas was opened, aspirated, explored digitally, and a cigarette-type drain containing a catheter in-

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serted. The patient enjoyed a good convalescence until the seventh postoperative day when profuse drainage was noted from the abdominal wound. After several days a fecal odor was noted from the drainage. Gram negative bacilli were identified. Streptomycin was again administered and oral intake stopped, this latter measure being advocated by Thomas and Ross to close pancreatic fistulae. By the twenty-first postoperative day the patient felt fine, was eating well and had slight drainage from the persisting sinus. Radio-opaque dye was injected into a catheter in this sinus. X-ray studies revealed that the dye progressed into the gallbladder, then through the cystic and common ducts into the duodenum. Fifteen minutes later the dye was seen in the transverse colon with none in the intervening small bowel. This indicated a duodeno-colic fistula. With conservative treatment of irrigation with tyrothricin, the sinus ceased draining and the patient was free of distress. At the time of this writing the patient was asymptomatic.

Discussion

These two cases are representative of the two types of duodeno-colic fistula. The first illustrates the more prevalent etiology of duodeno-colic fistula, i.e., carcinoma of the colon with extension into the duodenum. Following extensive resection, death followed leakage of the duodenojejunostomy due to failure to use non-absorbable suture material at the pancreatic bed. The second case represents a rare postoperative duodeno-colic fistula complicating surgery for acute pancreatitis. This patient recovered by conservative management.

Summary

Two cases of rare duodeno-colic fistula are reported. The first was due to carcinoma, the second followed surgery for acute pancreatitis.

PLACENTA ACCRETA FOUND AT CESAREAN SECTION

C. HOUSTON ALEXANDER, M.D.
DENVER

Placenta accreta, per se, is a comparatively rare complication of pregnancy with a reported incidence of one in 14,622 normal deliveries. Hirst reported one in 40,000 deliveries in 1947, and Irving and Hertig reported one in 1,956 cases in 1933. Greenhill defines placenta accreta as an abnormal adherence of the entire or part of the placenta to the uterine wall with partial or complete absence of the decidua basalis, especially the spongiosum layer. The normal separation of the placenta is facilitated by the spongy decidual layer. Following the expulsion of the fetus, the venous spaces fill with blood and as the contractions and relaxations of the musculature continue, separation occurs. If this layer is absent, it becomes obvious that the separation will be more difficult and the partial or complete absence of decidual compacta will make the separation even more difficult.

Shanon and Dodenhoff reviewed the factors initiating this condition in 1947 and concluded that this entity presupposes failure of an adequate decidual reaction and usually follows some disease or injury to the decidua. The majority of the reported cases occurred in multigravidae and were preceded either by a vigorous curettage, manual removal of the placenta or a previous cesarean section. Phaneuf adds such factors as: one, previous medication of a destructive or erosive type or vaporization employed in the uterus; two, the presence of submucous myomata with consequent atrophy of the overlying mucosa; three, affections of the endometrium, such as endometritis, septic puerperal infection, and pyometria; four, faulty position of the placenta such as placenta previa; and five, pregnancy in a uterine diverticulum.

Placenta accreta as found at cesarean section is even a more rare complication and its presence is usually of a coincidental or accidental nature with but a few exceptions. To date sixteen such cases have appeared in the literature and we are reporting another. Irving and Hertig reported a review of 104 cases of placenta accreta (all the reported cases up to 1937) in which three cases were found at section. They report one case in which the seventh and eighth pregnancies were complicated by postpartum hemorrhage and failure of normal placental separation. At the end of the ninth pregnancy the patient began to bleed freely so a classical cesarean section was performed followed by a hysterectomy.

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The author gratefully acknowledges the assistance of Drs. N. Paul Isbell and Gerard W. del-Junco in the management of this case and the preparation of this paper.

Examination of the specimen revealed placenta accreta. In another case, in which cesarean section was done because of hypertension, the placenta did not separate and an area of adherence to the posterior wall was found. A hysterectomy was performed. In a third case, in which a previous cesarean section had been performed, the placenta failed to separate and was found adherent to the old scar. This patient also received a hysterectomy. The remaining thirteen cases were from operations performed for partial or complete placenta previa, the majority of the cases being in the latter group. In all but two a Porro type operation was done; in the remaining two, reported by Potter, the placenta was left in situ and the patients recovered.

CASE REPORT

A 36-year-old, married, white, gravida 14, para 9, was admitted to the Denver General Hospital on May 23, 1949, for pyelitis with pregnancy. Her first eight term pregnancies were uncomplicated. In 1946 she delivered her ninth term pregnancy by cesarean section at another hospital. The indication for the previous section was an ovarian cyst. Her hospital record indicated that she had had a rather marked febrile postpartum course. She had had four previous spontaneous abortions followed by curettments in 1934, 1936, 1937, and 1940, respectively. Her last menstrual period was November 18, 1948, making her expected date of confinement August 25, 1949. Her pyelitis responded well to sulfadiazine therapy and she was discharged to the Prenatal Clinic on May 28, 1949. On August 2, 1949, the patient came to the hospital in early labor. Because of her previous cesarean section, a repeat cesarean section was performed yielding a 3027 gram female infant who cried spontaneously and continued to do well. When an attempt was made to separate and express the placenta it was found to be firmly attached to the right posterior wall of the uterus high in the fundus. The uterus bled profusely from the placental site due to manual attempts at removal. Hemostatis was secured only after supracervical hysterectomy. Her remaining postpartum course was uneventful. She was ambulatory on the first postoperative day and was discharged from the hospital on the tenth day.

This patient presents several of the possible etiological factors traditionally given for placenta accreta. She had had several previous pregnancies, four curettments, and a cesarean section complicated by endometritis.

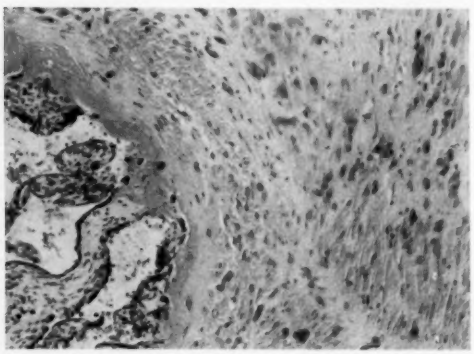

Fig. 1. Photomicrograph showing the invasion of a villus into the myometrium with obvious absence of the spongy layer of the decidua and the fibrous characteristics of the site of attachment.

Discussion

Prior to the advent of abdominal surgery the physician was limited to one of two alternate methods of management; one, manual removal of the placenta, piecemeal if need be; or, second, leaving the placenta in the uterus. The mortality for the former was approximately 72 per cent (1) while in the latter almost all patients died of excess hemorrhage, sepsis or both. As technics improved the treatment of choice was immediate hysterectomy as soon as the diagnosis was established. Phaneuf reports thirty-four cases with two deaths, a mortality of 5.8 per cent. With vaginal hysterectomy there were four fatalities in eleven cases or a mortality of 36.3 per cent. Five cases who had cesarean-hysterectomies had no mortality. In 1945 Aaberg stated that if a placenta accreta is encountered, the uterus should be packed at once with sulfanilamide gauze and an immediate supravaginal hysterectomy be performed. In 1947 Shannon and Dodenhoff reported a case of placenta accreta found at cesarean section performed for placenta previa with preservation of the uterus. They stated "when desire for future pregnancies is great, a more conservative method of treatment can be attempted, but only in the rare case when placenta accreta is accidentally found at cesarean section where the separation can be made under direct vision." In 1948 Muir reviewed fourteen cases in which the placenta was left in situ following vaginal delivery and, with chemotherapy and blood replacement, the patients recovered. He added a case of his own who had been treated conservatively and had subsequently delivered a normal infant with a normal third stage.

The infrequency of the condition is emphasized in that only sixteen previous cases have been reported in association with cesarean operations.

Organization

MONTANA
Medical Association

PROCEEDINGS OF THE INTERIM SESSION of the HOUSE of DELEGATES

March 16-17, 1951

The Fourth Interim Session of the House of Delegates of the Montana Medical Association was called to order by Dr. Clyde H. Fredrickson, President, at 9:30 a.m. in the Rathskeller of the Placer Hotel, Helena. Because of the temporary absence of Dr. E. H. Lindstrom, Helena, Assistant Secretary-Treasurer of the Association, President Fredrickson requested Dr. W. F. Morrison, Missoula, to act as Secretary pro tempore.

Following a roll call the Secretary announced that more than a quorum was present. It was moved by Dr. George M. Donich, Anaconda, and seconded that the reading of the minutes of the 72nd Annual Meeting of the House of Delegates held in Bozeman, July 9-10, 1950, be dispensed with inasmuch as these minutes have been published in the Rocky Mountain Medical Journal. Motion carried. It was then moved by Dr. J. J. Malee, Anaconda, and seconded that the minutes of the 72nd Annual Meeting of the House of Delegates be approved as published in the September, 1950, issue of the Rocky Mountain Medical Journal. Motion carried. The following report of our delegate to the meeting of the House of Delegates of the American Medical Association was read by Dr. R. F. Peterson of Butte:

The 1950 Clinical Session of the American Medical Association was held in Cleveland, Ohio, December 5-8 and was planned especially for those interested in the general practice of medicine, as are all other Clinical Sessions. The attendance was good, but not nearly as good as it should have been. There were several reasons for this. The meeting place was suddenly changed from Denver to Cleveland because Denver was unable to complete their auditorium in time; the weather in Cleveland the week prior to the meeting was most inclement.

Actions of the House of Delegates during the Clinical Session included the approval of a $500,000 donation to establish the American Medical Education Foundation, which will provide financial assistance to medical schools throughout the United States with no strings attached; the establishment of a new section on military medicine to emphasize its increasing importance in the United States.

The problem of federal aid to medical schools was discussed at length. These discussions always concluded with the fundamental fact that he who foots the bill controls the policy. This is agreed to in general—even by the Supreme Court of the United States.

The practice of medicine by hospitals was discussed and again condemned. Your delegate was selected with another pathologist, two radiologists and two anesthesiologists, as a member of a special group to discuss an acute situation existing in Cleveland where Blue Cross hospitals were attempting to include the practice of medicine under their plan rather than under the Physicians' Service Plan.

Your delegate was also a member of the important Committee on Legislation and the Committee on Public Relations. Hearings before the Legislative Committee disclosed the different types of public health services throughout the country, as well as the different philosophies. The testimony, not only from general practitioners, but also from public health personnel, was lengthy and heated. The report of this committee emphasized that "the services of departments of public health should be limited to (1) vital statistics; (2) public health education; (3) environmental sanitation; (4) public health laboratories; (5) prevention and control of communicable diseases; and (6) hygiene of maternity, infancy and childhood, if private facilities are unavailable." A bill, HR 9914, recently introduced in the United States Congress, included the definition of public health services which reflected the opinion of this committee. It restricted such services to "(1) health information and education; (2) laboratory services; (3) vital statistics; (4) communicable disease control; (5) environmental sanitation; (6) maternal and child health demonstration, and (7) training of personnel for local public health work or other aspects of preventive medicine." The bill specifically excludes medical or dental treatment except where necessary for the control of communicable diseases or to meet epidemic or other emergency situations. It also excludes without qualification programs for industrial accident prevention.

The Legislative Committee concluded that cabinet rank for medicine is unattainable and inadvisable at this time. The same results can be achieved by the establishment of an independent agency with an executive status in which all federal health activities are coordinated, except the medical departments of the Departments of Defense and the Veterans Administration. The plan would be to establish such an agency as a non-political department similar to the Federal Bureau of Investigation.

The 1951 Clinical Session of the American Medical Association will be held in Houston, Texas, during December and the 1952 session will be held in Denver. All physicians are urged to attend these important sessions.

There being no objection, the report of the delegate was ordered placed on file. The Secretary pro tem then read the following report of the Secretary-Treasurer, Dr. H. T. Caraway:

Your executive office has indeed been a busy one. It handles each month a large volume of correspondence. There is a monthly mailing of between 1,000 and 1,200 letters, including the Bulletin, which is sent to every physician in the state on the first day of each month. There is also considerable correspondence with association members, the American Medical Association and the office of Whitaker & Baxter, directors of the National Education Campaign. Your Secretary-Treasurer and the staff of the executive office are making every effort to perform a valuable service to the membership and to assist the individual member in every way possible.

The records in the executive office indicate that during 1950, 446 Montana physicians were members of the Montana Medical Association in good standing; of this number, 398 were members of the American Medical Association in good standing. As of today, 324 members have remitted their dues for 1951 in the state association and 321 have remitted 1951 dues in the American Medical Association. The collection of 1951 dues, both in your state association and the American Medical Association, has been slower than last year. It is the hope of your officers, however, that with the cooperation of the Secretary and the Treasurer of each component society, payments of 1951 dues will improve and that in the near future all Montana physicians will be members in good standing of your state association and the American Medical Association.

Because there has been some confusion and misunderstanding about the dues of the American Medical Association, your Secretary-Treasurer would like to take this opportunity to explain the various classifications of membership in the A.M.A. and to inform you, as delegates, about the dues in the American Medical Association. In 1949, the A.M.A., through its House of Delegates, voted to assess each physician $25.00. This was a voluntary assessment and did not affect membership in the American Medical Association, because at that time any

physician who was a member in good standing of the state association was automatically a member in good standing of the A.M.A. In 1950, the House of Delegates of the American Medical Association voted that each of its members should be required to remit annual dues. These dues were fixed at $25.00 per year by the Board of Trustees and were membership dues. In 1951 the House of Delegates of the A.M.A. and its Board of Trustees fixed membership dues at $25.00. These bodies, however, voted that during 1951 the membership dues would include a subscription to the Journal of the A.M.A. Actually, this amounted to a reduction in dues in the national association because a subscription to the Journal of the A.M.A. amounted to $12.00. When the administrative bodies of the American Medical Association voted to include a subscription to the Journal as a part of the membership dues, it also voted to fix the Fellowship dues at an additional $5.00 per year. Members of the American Medical Association who become Fellows are entitled to subscribe to any one of the specialty journals published by the A.M.A. rather than the Journal. When these revisions in the membership and Fellowship classifications of the A.M.A. were made, the Board of Trustees also determined that physicians must be members in good standing for 1950 before membership dues for 1951 may be accepted.

During September, 1950, Dr. G. D. Carlyle Thompson assumed his duties as executive officer of the State Board of Health. One of his first projects was a tour of the state to discuss public health and the establishment of public health departments with the citizens and physicians of each community. During November and December, meetings with the citizens and with the physicians were conducted in thirteen communities throughout the state. At each of these meetings your Executive Secretary and a member of the Executive Committee were present to represent your association. Generally, the meetings were very well attended and the citizens in each community expressed a great deal of interest in the establishment of local, county or multicounty health departments. It is anticipated that health departments will be established in the near future in two or three of the eastern counties on a full-time basis.

During December your Secretary-Treasurer and Executive Secretary attended the Third National Public Relations Conference of the American Medical Association and the Clinical Session and meeting of the House of Delegates of the A.M.A. in Cleveland. The Public Relations Conference was particularly outstanding and of great interest to your representatives. The value of good public relations and the very important part played by the component medical societies in any program of public relations was emphasized. It was pointed out that the American Medical Association may develop and suggest a number of good public relations programs to state associations and to component medical societies. The actual implementation of these programs, however, is dependent upon the state association and, to an even larger degree, upon the local medical societies. Good public relations, it was suggested, is a job for every individual physician, meeting the public as he does on the grass-root level. A great deal has been accomplished during the last two or three critical years. Much more must be done during the coming years, which give promise of still more trying times.

Your Secretary-Treasurer and the executive office of your state association have cooperated closely with Whitaker & Baxter, directors of the National Education Campaign. Members of the House of Delegates will recall that last fall, immediately preceding the November elections, an intensive advertising campaign was conducted. The A.M.A. National Education Campaign inserted large advertisements in 10,300 newspapers and purchased time for spot announcements on more than 1,600 radio stations. In line with this program, your executive office contacted nearly 500 advertisers throughout the State of Montana to suggest that they cooperate with the medical profession in this advertising campaign. As a result, many firms throughout the state did purchase advertising space or radio time to further implement the advertising message of the American Medical Association. Also, your executive office notified all of the component societies of the radio advertising campaign and suggested that, wherever possible, the local society arrange to purchase time on radio stations not included in the radio broadcast schedule of the American Medical Association. Your Secretary-Treasurer is very happy to report that the spot announcements prepared by Whitaker & Baxter were carried on practically every radio station in Montana as a result of the cooperation of the local societies.

During December, your executive office, with the authorization of the House of Delegates, published a booklet which contained the proceedings of the First Montana Conference on the Cooperation of the Physician in the School Health Program. This booklet was distributed to all physicians, dentists, public health personnel and all others interested in school health throughout the state. This was a most worthwhile project and one which is of great public relations value to the medical profession.

Each month your Secretary-Treasurer and the executive office prepare a monthly Bulletin which is sent to every physician in the State of Montana. We have made every effort to publish in this Bulletin each month facts and information of interest to the physicians in Montana. We hope that each member reads the Bulletin and that he enjoys it as much as we enjoy preparing it.

I regret that I shall not be present at the Interim Session to read this report, as I shall have commenced my tour of active duty with the Medical Corps of the U. S. Air Force at Randolph Field, Texas. It has been a privilege and an honor to have served as Secretary-Treasurer of your association and I shall always cherish the many friendships I have made. Even though I am looking forward to my tour of duty with the Air Force, I shall miss the activities of the medical association. I hope that on my return I shall be able to resume an active part with your association.

In closing, may I take the opportunity to wish my successor, Dr. Lindstrom, each officer and each member of the association every success.

There being no objection, this report was placed on file. After the presentation of the report of the Secretary-Treasurer, President Fredrickson read a telegram from Dr. Caraway extending his greetings to the members of the House of Delegates and his best wishes for a successful meeting.

Dr. E. H. Lindstrom, Assistant Secretary-Treasurer, read the following report of the Executive Committee.

Since the last annual meeting of the association in Bozeman during July, 1950, the Executive Committee has held four meetings to transact certain business of the association which required immediate action. The following represents some of the more important actions of the Executive Committee and are presented for the information of the members of the House of Delegates.

Incorporation of the Association: Pursuant to the authority given the Executive Committee by the House of Delegates at its last meeting, this committee in September, 1950, instructed our legal counsel to proceed to incorporate the association. The necessary Articles of Incorporation were prepared by our legal counsel and, after approval by this committee, were filed with the Secretary of State. On January 9, 1951, the Secretary of State issued the certificate of incorporation.

With the completion of incorporation, the Constitution of this association was replaced with the new Articles of Incorporation. Under the laws of the State of Montana, it was necessary that the By-Laws of the association be re-adopted and a corporate seal adopted and that this business be transacted by the membership. Accordingly, the central office mailed to every member of the association notice of a meeting of the membership to be held in the office of the corporation in Billings on February 8. This notice was accompanied by a proxy and assent to the By-Laws, which, in effect, authorized the Executive Committee of the association to act in the name of the member who signed and returned the assent. Immediately following this meeting of the membership, the Executive Committee of the association met to re-elect the present officers.

The completion of these actions within thirty days after the issuance of our certificate of incorporation concluded all of the necessary formalities to accomplish incorporation. Your association, therefore, is now a legally constituted corporate body, organized as a non-profit association.

Dues of Members on Active Military Duty: As a result of the war in Korea, a number of members of this association have volunteered for active duty with the armed forces. The Executive Committee is of the opinion that these individuals should not be required to remit annual dues in the association and recommends that these dues be waived during the time such members are engaged in active military service and that these individuals be carried on the roster of members in good standing until January 1 or July 1, whichever comes first, following their discharge from active duty. In order to conform with the dues requirements of the American Medical Association, this committee also recommends that the dues of any member called to active duty before July 1 of any year be reduced to one-half of the dues for that year; if called to active

duty after July 1, such members should remit the full dues, but will be excused thereafter from the payment of dues while on active duty.

Annual Meeting of Association: After careful consideration by the Executive Committee of the most desirable dates to hold the annual meeting of the association, it was agreed that the 1951 meeting be held September 13-16 in Great Falls. The Executive Committee also agreed that the scientific session of the association should be planned the first two days of the session, that is, September 13 and 14; and that the sessions of the House of Delegates be held the last two days, or September 15 and 16. It is the feeling of the Executive Committee that this revised arrangement for the conduct of the annual meeting and that the fall dates will improve the attendance.

Legislative Proposals: Because of the session of the Thirty-second Legislative Assembly during the first sixty days of this year, the Executive Committee, in cooperation with the Legislative Committee of your association, reviewed a number of legislative proposals. All of these were referred to the Legislative Committee with a recommendation. A more detailed report upon them will be presented by that committee subsequently.

Amendments to By-Laws to Create Office of Assistant Secretary-Treasurer: Early in November, Dr. H. T. Caraway, who was serving as Secretary-Treasurer of this association, advised the Executive Committee that he had recently been commissioned a Major in the Medical Corps of the U. S. Air Force Reserve and that he anticipated receiving orders to duty in the near future. In view of the possibility of a vacancy in this office, it seems imperative to the Executive Committee that provisions be made in the By-Laws to create the office of Assistant Secretary-Treasurer so that this officer might assume the duties of the Secretary-Treasurer of the association whenever that officer is unable to function for any reason whatsoever. Accordingly, your Executive Committee strongly recommends the adoption of certain amendments to the By-Laws to create this office. Because of the probability that the Secretary-Treasurer, Dr. Caraway, would be ordered to active duty before the annual meeting of the House of Delegates and the annual election, your Executive Committee has appointed Dr. E. H. Lindstrom to serve as Assistant Secretary-Treasurer and to assume the duties of the Secretary-Treasurer when Dr. Caraway was called to active duty. Dr. Caraway left Billings March 1 in order to report for active duty at Randolph Field, Texas, by March 18. Therefore, Dr. Lindstrom is now serving our association as Acting Secretary-Treasurer until the next annual meeting and election. It is the recommendation of the Executive Committee that the House confirm the appointment of Dr. Lindstrom to serve until the next annual election.

Appointment of I. J. Bridenstine to Executive Committee: Because there was a vacancy on the Executive Committee, due to the death of Dr. Thomas F. Walker, your President has appointed, with the concurrence of the Executive Committee, Dr. I. J. Bridenstine of Missoula as a member of the committee to serve until the next annual election of the association in September. It is the recommendation of the Executive Committee that the House confirm the appointment of Dr. Bridenstine to serve until the next annual election.

By-Laws of the Association: In view of the recent incorporation of the association and in view of the fact that the By-Laws are now somewhat outmoded, your Executive Committee has authorized President Fredrickson to appoint a special committee to review and rewrite these By-Laws. Your President has appointed the following as members of this committee: Dr. Thomas L. Hawkins, Helena, Chairman; Dr. Paul J. Gans, Lewistown; Dr. Eaner P. Higgins, Kalispell; Dr. Wyman J. Roberts, Great Falls, and Dr. Maurice A. Shillington, Glendive. Each of these appointees has accepted the assignment.

Group Health and Accident Insurance Plans: Your Executive Committee has authorized the Executive Secretary of your association to explore the various group health and accident plans. Your committee is hopeful that a group health and accident plan can be organized for the benefit of the members of this association and expects to present such a plan for the consideration of the House of Delegates in September.

There being no objection, President Fredrickson ordered this report placed on file. The recommendations of the committee were then considered separately. It was moved by Dr. Lindstrom that the recommendation of the Executive Committee to waive the dues of members on active duty with the armed forces be approved and that the following policies on the waiver of such dues be adopted: (1) That members in good standing who are called to active duty prior to July 1 of any year be required to remit only one-half of the dues in this association for that year; that those who are called to active duty after July 1 of any year remit the full dues for that year; (2) That members in good standing who are called to active duty before July 1 of any year will, upon request, receive a refund of one-half of their annual dues if they were remitted in full before such member was called to active duty; (3) That the dues of members in good standing be waived during the period they are on active military duty and their names be retained on the roster of members during that period; (4) That such members be carried on the membership roster in good standing until January 1 or July 1, whichever comes first, following their discharge from active duty. The motion was seconded and carried. Dr. Lindstrom then moved that the House of Delegates confirm the appointment of Dr. I. J. Bridenstine, Missoula, to serve as a member of the Executive Committee of the Montana Medical Association until the next annual election. The motion was regularly seconded and carried. Dr. W. F. Morrison, Missoula, then moved the House of Delegates confirm the appointment of Dr. E. H. Lindstrom as Assistant Secretary-Treasurer of the Montana Medical Association to serve until the next annual election. This motion was regularly seconded and carried. For the information of the members of the House of Delegates, Dr. Lindstrom then read the proposed amendments to the By-Laws to create the office of Assistant Secretary-Treasurer. In compliance with the provisions of the By-Laws, the final vote upon these amendments was deferred until March 17.

In the absence of Dr. I. J. Bridenstine, Chairman of the Legislative Committee, the following report was read by President Fredrickson:

The chairman of the Legislative Committee begs leave to take this opportunity to thank those members of the committee residing in Helena and all other members of the association who expended time and effort on behalf of legislative matters affecting the association during the 1951 session of the Montana Legislative Assembly. Your chairman also wishes to express the deep appreciation of this committee to Dr. Evon L. Anderson, Senator from Choteau County, for his cooperation and assistance. Our committee highly commends Dr. Anderson for his accomplishments in the Senate on behalf of the medical profession and of his constituents.

Your chairman especially wishes to commend the fine work done by your Executive Secretary, Russell Hegland. Mr. Hegland was in Helena during most of the legislative session and due to his vigilance we were spared much adverse legislation.

Herewith is a summary of the legislation introduced in the 1951 session with which we were concerned:

House Bill 35, introduced early in the session, would have made malpractice by physicians or surgeons a felony. It was referred to the Judiciary Committee and was not passed because of their adverse recommendation.

House Bill 143, the chiropractors bill, proposed to amend four sections of the present law on the practice of chiropractic. A substitute bill which increased the educational requirements and the renewal license fee was offered and was passed by both Houses.

House Bill 162 amended laws relating to the needy blind. It authorized optometrists to examine applicants and recipients of assistance to the blind, but required an examination by an ophthalmologist if treatment was necessary. This revision of laws relating to the needy blind was required in our state in order to qualify for federal aid in conformity with requirements of the federal laws as amended in the last session of Congress. This bill passed both Houses and was signed by the Governor.

House Bill 229 was an act to amend the laws relating to adoptions. It is quite similar to the bill offered for the approval of the medical association

last year. This bill requires that a report from a representative of the State Department of Public Welfare or any licensed adoption agency as to the condition and surroundings of the home of proposed adoptive parents shall be presented to the court; that this report shall be filed within twenty days of the filing of the petition for adoption; and that no order of adoption shall be made final until the filing of such a report or the expiration of the time for filing it. Heretofore, no such investigation of the proposed adoptive home or parents has been required. This bill passed and was signed by the Governor.

House Bill 264 amended the Enabling Act of 1945 which provided for the establishment of district and county health units. It passed the House, but was killed in the Senate by an adverse committee report. This bill had been approved by the Montana Medical Association.

House Bill 265 was an act to permit reorganization of the divisions of the State Board of Health which was approved by our Executive and Legislative Committees. It would have effected some efficiency and economy in the State Board of Health. It passed the House after only slight opposition. In the Senate it was referred to the Committee on Public Health and Sanitation, where it was buried. This committee took no action on the bill and did not report it out on the floor of the Senate.

House Bill 272 would have authorized pay roll deductions for the purchase of United States bonds or the payment of premiums for health insurance by the state departments. The State Auditor opposed the bill on the grounds that it would be too cumbersome and expensive a procedure to make these pay roll deductions. It did not pass the House.

House Bill 340 was an enabling act ratifying and adopting the Western Regional Higher Education Compact which was approved by the Western Governors' Conference at a meeting in Denver on Nov. 10, 1950. The Montana Medical Association has, for the past year or two, considered and urged enactment of some type of legislation that would insure entrance to a medical school for pre-medical graduates from our Montana University system. This legislation appeared to provide the necessary means to do this and its enactment, therefore, was urged by your committee and officers. The compact, which may include eleven western states and the Territories of Hawaii and Alaska, becomes operative and binding upon those states and territories ratifying it as soon as five have adopted it prior to July 1, 1953. It becomes binding and effective on any additional states as soon as they have ratified it. Provision is made for the withdrawal of a state and also for handling defaults by any of the states or territories.

The compact, as it now reads, will aim at facilitating education in the fields of medicine, dentistry, public health and veterinary medicine, with the way left open for work in other professional or graduate fields. The compact creates a commission called the Western Interstate Commission for Higher Education. This commission consists of three resident members from each compact state or territory; one member to be, at all times, an educator engaged in the field of higher education in the state or territory from which he is appointed. The terms of the commissioners are to be for four years and appointment is by the governor of the state.

The commission is enjoined and empowered to enter into contractual agreements with institutions in the region offering graduate or professional education and with any of the compacting states or territories as may be required to provide adequate service and facilities of graduate and professional education for the citizens of the respective compacting states and territories. The commission is also enjoined to undertake studies of needs for professional and graduate education facilities in the region, the resources for meeting such needs and the long-range effects of this on higher education. It is also instructed to make reports on such research to the Western Governors' Conference and to the legislative assemblies of the compacting states and territories. The commission is empowered to draft and recommend to the governors of the compacting states and territories uniform legislation dealing with the problems of higher education in the region. The operating cost of the commission is to be borne equally by the compacting states and territories.

In the region included in this compact there are now eight schools of medicine, five schools of dentistry, three schools of veterinary medicine and one school offering a full program of graduate training in public health. Montana, Wyoming, Idaho, Nevada, Arizona, New Mexico, Alaska and Hawaii have no schools of any of these branches of higher education. This compact will be of distinct advantage to the states and territories that have no schools of medicine, dentistry and veterinary medicine. It will be two years at least before any definite arrangements can be made for the exchange of students because it will take that much time to secure ratification by the required five states or territories as stated in the compact. It does not meet our immediate needs, but does promise something definite for the future. House Bill 340 was passed by both Houses and has been signed by the Governor.

House Bill 365 was known as the "DP Bill." It proposed amendments to the Medical Practice Act that would allow displaced physicians to practice in Montana without meeting certain requirements now in force. This bill was referred to the Judiciary Committee, which returned it with a "do not pass" recommendation and the bill died.

House Bill 444 was another amendment to the existing adoption laws which did not pass.

Senate Bill 42 amended the laws relating to pharmacy. It outlaws the coding of prescriptions, provides that "non repetatur" or an abbreviation of the same written on a prescription makes it unlawful to refill that prescription; that prescriptions marked to be refilled by a specified amount may be refilled that many times; and that a prescription not bearing any such limitation may be refilled at will. This bill passed both Houses and was signed by the Governor.

Senate Bill 52 was the Nurses Bill. This bill has probably received more consideration by your Legislative Committee and other members of the medical association than all of the other pieces of legislation recorded in this report. As happened in the 1949 session of Legislature, the nurses were apparently divided in their opinions when in conference with the Senate Committee on State Boards and Offices to which the bill had been referred. Seeds of doubt as to the medical association's approval of this bill had also been planted in the minds of some of the members of the Committee on State Boards and Offices by members of our own association. Senator Toman from Powder River County called the chairman of the Legislative Committee about this. The Senate committee reported the bill to the floor of the Senate with a recommendation that it "do not pass." It was killed.

Senate Bill 75, introduced at the request of the Highway Department, required that physicians report the names of individuals having certain diseases to the State Board of Health, which in turn would have been required to report said names to the Highway Department. This bill passed the Senate and House, but was vetoed by the Governor. This bill dealt chiefly with epileptics.

Senate Bill 107 would have eliminated Plan 2 under the Workmen's Compensation Act. It was opposed by the insurance representatives, physicians and many others. It failed to pass.

Senate Bill 131 would have exempted from the provisions of the Dental Practice Act any person who had practiced dentistry in the same location for a period of twenty years prior to the passage of this bill. This bill was introduced solely as a favor to one person in the state who has practiced dentistry for twenty years in one place and who possesses neither a license to practice nor is a graduate of a dental school. The bill, referred to the Public Health Committee, was reported out of that committee with a "do not pass" recommendation, but was carried to third reading by parliamentary maneuvering. It failed to pass, however, on the final vote.

Your Legislative Committee has no especial recommendations to make at this time.

There being no objection, this report was ordered placed on file. Dr. J. J. Malee moved and Dr. C. F. Little, Great Falls, seconded that Senator E. L. Anderson, the Legislative Committee and the Executive Secretary of this association be commended for their fine work during the period of the Thirty-Second Legislative Assembly. Motion carried. It was then moved by Dr. W. F. Cashmore, Helena, that the Secretary be authorized to write a letter of commendation to Senator Anderson. This motion was regularly seconded and carried.

The following report of the Necrology and History of Medicine Committee was read by the chairman, Dr. L. W. Brewer, Missoula:

Since our regular meeting in July, 1950, the members of the Montana Medical Association have been saddened by the death of the following seven members:

Dr. George E. Armour of St. Ignatius died on Aug. 1, 1950, of arteriosclerosis at the age of 69. Dr. Armour was the possessor of a degree in pharmacy as well as in medicine; the latter from the Sioux City College of Medicine in 1905. He practiced

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1. Douglas, R. G.; Ball, T. L., and Davis, I. F.: California Med. 73:463 (Dec.) 1950.
2. Pratt, P. T.: Nebraska State M. J. 35:294 (Sept.) 1950.

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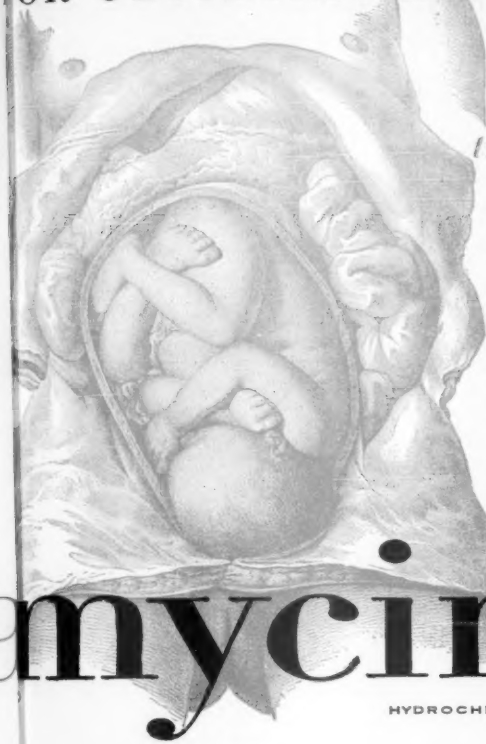

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in Nebraska from 1906 to 1911; in Lambert, Montana, from 1912 to 1923; and in St. Ignatius from 1923 to 1946, at which time he retired. He is survived by his wife, one son and four daughters.

Dr. Oscar G. Benson of Plentywood died of cerebral hemorrhage Dec. 14, 1950, at the age of 44. A graduate of Creighton University School of Medicine in 1935, he practiced in Montana from 1936 to 1950. He is survived by his wife, two sons and one daughter.

Dr. George H. Freeman, late superintendent of the Montana State Hospital at Warm Springs, died in Butte on Dec. 2, 1950. He is survived by a son, John G. Freeman, who is also a physician. Dr. George Freeman graduated from the University of Minnesota Medical School in 1905. He had extensive psychiatric hospital administrative experience in Minnesota between 1906 and 1948, before coming to Montana in 1948. Dr. Freeman had served as psychiatrist to the Minnesota State Board of Parole, was a lecturer at the University of Minnesota between 1937 and 1939, was a member of the Medical Advisory Board of the Minnesota State Medical Association and was a Life Fellow of the American Psychiatric Association.

Dr. John H. Garberson of Miles City died of cardiac decompensation on Aug. 9, 1950, being survived by his wife, one son and three daughters. Dr. Garberson, long identified with the highest type of surgical practice throughout his years in Montana, was graduated from Northwestern University Medical School in 1907; he came to Deer Lodge in 1908 and from 1909 to 1950 practiced in Miles City. He was a Fellow of the American College of Surgeons and of the International College of Surgeons, a Diplomate of the American Board of Surgery and a high official of Rotary International. He had served as President of the Montana State Medical Association.

Dr. Arthur L. Weisgerber of Great Falls died on Dec. 16, 1950, of coronary thrombosis at the age of 67. He is survived by his wife, who resides in Great Falls, and by a brother and sister in California. Dr. Weisgerber graduated from the Kansas Medical College and practiced in Montana from 1910 to 1950.

Dr. Thomas F. Walker of Great Falls died Oct. 22, 1950, in Great Falls at the age of 60, of carcinoma of the lung. Dr. Walker is survived by his wife, Dr. Dora Walker, and his son, Dr. Thomas Walker, Jr. He was graduated from the University of Colorado School of Medicine in 1912 and spent his entire active professional life as a pathologist in Great Falls. For more years than many of us have lived in the state, Dr. Walker has been identified with the affairs of the State Medical Association, having served as its Secretary and as its President. He was a Diplomate of the American Board of Pathology, a Fellow of the American College of Physicians and a member of the American Society of Clinical Pathologists.

Dr. Hugh M. Ware died of pulmonary embolism on Oct. 9, 1950, at Warm Springs at the age of 66. Among the surviving members of his family are a brother-in-law, Dr. E. G. Barton, and a nephew, Dr. E. G. Barton, Jr. Dr. Ware graduated from the University of Michigan Medical School in 1910. He had practiced in Warm Springs from 1946 until the time of his death.

It is fitting that the passing of these members be recorded with sorrow upon our minutes. It is especially fitting that the loss of Dr. Garberson, long a master surgeon, a diligent student of his art, a worker for the entire profession and a servant of the Montana Medical Association in its highest office, be marked with a particular regret by us all. And in a peculiarly personal way do we each feel the passing of Dr. Tom Walker. His warm personality, his sense of fairness, his disregard of personal sacrifice and discomfort in the face of physical handicaps, which were not trifles, were personal attributes which endeared him to each of us. From his work on the State Board of Health, helping to give us now the chance to strengthen its effectiveness; from his service in promoting the first full-time county health office in this state; from his support in the Montana Physicians' Service, even though its provisions do not compensate his specialized work as well as they do some others; from his interest in the Mediation Committee which is soon to be a feature of our association; from these few examples of Tom Walker's influence on Montana's medicine we can each take inspiration to do a better job on the problems that confront us. It is a privilege for us now to punctuate this meeting by standing in silence for a moment in respect to these men. The committee wishes to report that a short biography of each of the deceased members of the association has been filed with the office of the Secretary. With your approval, a letter on behalf of the association will be written to the surviving family of each.

Our report about the project on the History of Medicine in Montana is distinctly gloomy. During the year three graduate students at the university have been approached by Dean Burly Miller with a request to survey the material now available, but as yet no one has been secured who can or will undertake this as a personal project. The difficulty is that, from the standpoint of a student of history, our material, which was gathered by Judge Calloway, cannot be verified. Whatever notes were employed in writing the narrative have been destroyed or lost; so unless the entire project is undertaken anew, and the material regathered and checked, the professional historian would regard our present material as purely a collection of gossip. Dean Miller advises that he will continue throughout this year to try and contact a graduate student who would have some special interest in undertaking the project. This committee proposes to investigate some other way of bringing the assignment to fruition and to make definitive recommendations at the annual meeting in September of 1951. No money has been expended by the committee in the past year and a half. The $100.00 appropriated for the purposes of the committee at the last regular meeting should be more than sufficient for any expense which is expected during the current year.

It was moved, seconded and carried that the report of the Committee on Necrology and the History of Medicine be accepted.

Dr. Louis W. Allard, Billings, Chairman of the Committee on Legal Affairs and Malpractice, presented the following report:

Your Legal Affairs and Malpractice Committee has taken an interest in several matters that have been directly or indirectly called to its attention. Members of this committee have investigated the merits of several complaints and threatened suits.

Manifestly, the extent to which this particular committee can impose itself in matters of misunderstanding is limited by the circumstances in each case. By contacting insurance attorneys and discussing problems with the physicians involved, the committee works itself into a position where it can be of advisory assistance without interfering or involving itself in the legal side of any problems that might be carried into court.

The committee tries to take a factual attitude and does not intend to set up a secondary defense where the defendant is manifestly liable; it does try to bring about peace and tranquillity and at least tolerance in its relationship with those who are unhappily involved in a threatened suit. In those cases where an unfair and unjust advantage is taken by someone who thinks he has an opportunity to enrich himself at the expense of one of our physicians, then I think that the medical profession, as well as the committee, should go all out in the defense of an unjust accusation. With this in mind, your committee stands ready to investigate, analyze and assist wherever its services will be of value.

There being no objection, the report was placed on file.

The Chairman of the Program Committee, Dr. J. J. Malee, read the following report:

Your Program Committee wishes to report that the Interm Session has been completely arranged and, for the first time, is presenting a Clinical-Pathological Conference. We hope that in the future our state association shall be able to again have a Clinical-Pathological Conference, if the membership so desires. Your Interim Session has been well arranged and the program is going to be of interest to every physician.

Your Annual Meeting will be held in Great Falls, September 13-16. We have asked that the associated groups arrange their meetings on Thursday night, September 13, so as not to interfere with meetings of the parent group. There will be a banquet on Friday, September 14, in which both the Montana Medical Association and the Academy of Oto-Ophthalmology will share. We have a commitment with the medical faculty of the University of Washington and we expect it to provide the scientific sessions for our meeting in Great Falls. We have also been asked by the National Foundation for Infantile Paralysis to utilize one of its speakers. We are very grateful for the continued support of the Executive Committee and the membership.

This report was placed on file, there being no objections.

The following report was presented by Dr. F. L. McPhail, Great Falls, Chairman of the Public Health Committee:

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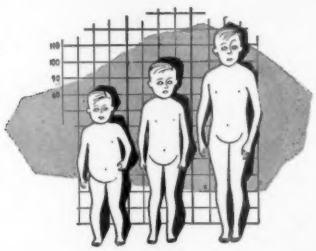

The Pediatrician has found that aureomycin is promptly and fully effective in his young patients. Infections in any part of the respiratory tract, due to susceptible organisms, are as a rule readily controllable by its means, as are most meningeal infections caused by staphylococci, streptococci, pneumococci, *H. influenzae* and *E. coli*. In the infectious diarrhea of infancy, aureomycin, in conjunction with fluid and electrolyte replacement, has given excellent results. Aureomycin is a drug indispensable to pediatric practice.

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The Public Health Committee has had one meeting this year. This meeting was well attended and a number of matters pertaining to health legislation were discussed and forwarded to the Executive Committee. As this has been discussed by the Legislative Committee in its report, further discussion is not necessary now.

One matter brought before the members of this committee concerned a review of the miniature film survey of chests in this state. It was presented to the committee for the purpose of discussing the advisability of approving the use of 14x17 equipment on mobile chest x-ray survey units. Because this matter was of interest to several other committees, the subject was referred to the Tuberculosis Committee, the Cancer Committee and the Rheumatic Fever and Heart Committee. After consideration by these committees, their reports were forwarded to the Executive Committee. The Tuberculosis and Cancer Committees were opposed to the use of 14x17 film study and the Heart Committee was favorable to the plan. These reports were referred to the Public Health Committee by the Executive Committee. No recommendation is being made, however, by the Public Health Committee.

President Fredrickson ordered the report placed on file, there being no objections.

The report of the Interprofessional Relations Committee was then read by Dr. Louis W. Allard, Chairman:

The Interprofessional Relations Committee has stood ready at all times to confer and cooperate with the dentists, nurses, pharmacists and hospitals in any matter that involved these integrated professions in their relationships to public welfare. During the past two years members of this committee, along with the officers of the medical association, have taken a keen interest in assisting the state nurses association and the practical nurses association in the development of a legislative bill that would recognize these two groups of the nursing profession. In particular, it is felt that legislative recognition would provide controls, education and standards of professional conduct that would in turn provide a list of qualified practical nurses in whom the medical profession would have confidence. Some thirty-two other states have passed such legislative measures and these programs seem to be working satisfactorily. On several occasions members of your Interprofessional Relations Committee have met with the proper committees and officers of the nurses association and the practical nursing group. There was a remarkable feeling of friendly cooperation noted between the two nursing groups working together and with legal assistance they had worked out a bill that seemed sufficient and satisfactory to all concerned, including your representatives from the medical profession. Unfortunately, and for reasons that have not yet been analyzed by your committee, this bill failed passage at the last legislative session. It is the opinion of the Interprofessional Relations Committee that this bill should not be dropped. It should again be presented to the next Legislature. It has been suggested by leaders in the nursing field that the Hospital Association of Montana be approached with the idea of establishing a practical nurses training program and that these nurses be given some type of certification on the completion of a training course that satisfied the hospital management, the nursing profession and the medical profession. There has been a need for qualified practical nurses. This need is becoming greater as time goes on. The inspiration to start a practical nurses training program in the near future will now be given more thoughtful study by all concerned.

In conclusion, it may be stated that the relationship between the five professional groups directly interested in public welfare has been pleasant, a situation which bids well for the future.

This report was ordered placed on file by President Fredrickson.

The Chairman of the Cancer Committee, Dr. W. F. Cashmore, Helena, presented the following report to the House of Delegates:

Representatives of the Cancer Committee met with the Public Health Committee on Nov. 19, 1950, when the proposal to extend the tuberculosis x-ray survey program was discussed. The chairman of the Cancer Committee opposed the proposition of Dr. G. D. Carlyle Thompson, Executive Officer of the State Board of Health, to expand the tuberculosis survey program to include the use of 14x17 x-ray films. Because of the inclement weather and for other reasons, a poll of the membership of the Cancer Committee was taken on this question. The members of the committee tentatively approved the action of its chairman and asked that the question be referred to the House of Delegates. (See report of the Public Health Committee above.)

This report was placed on file since there was no objection.

Dr. Cashmore then moved that the Montana Medical Association continue to cooperate with the State Board of Health and its various divisions in the performance of its established functions in preventive medicine and the control of communicable diseases. This motion was seconded and carried. Following approval of this motion Dr. Cashmore discussed the work of the Montana Division of the American Cancer Society and its program of education. He urged physicians as individuals to assist their local chaper and to offer guidance so as to properly influence the medical aspects of the program of this organization.

Dr. H. V. Gibson, Great Falls, Chairman of the Tuberculosis Committee, read the following report:

The Tuberculosis Committee of the Montana Medical Association met in Helena, Feb. 4, 1951. Dr. Philip D. Pallister, Boulder, attended this meeting as a representative of the Cancer Committee, and Dr. G. D. Carlyle Thompson and Dr. William F. Kimmel of Helena represented the State Board of Health.

A communication from the Secretary of the Montana Tuberculosis Association suggested that a standard fee for chest x-rays be adopted when the Tuberculosis Association finances the cost of such film for indigent and near indigent persons as determined by their family doctor. Following a discussion of this proposal, it was recommended that this committee propose that a fee of $5.00 be established. This motion was seconded and carried unanimously. Dr. G. D. Carlyle Thompson, Executive Officer of the Montana State Board of Health, was then asked to discuss in detail the tuberculosis survey as it is now being conducted throughout the state by the State Board of Health and also the future plans of this board for continuing the survey. After discussion it was moved, seconded and carried that this committee recommend that the chest x-ray survey, using miniature film, be continued throughout the state. Following the approval of this motion, the use of 14x17 x-ray film for follow-up in cases of suspected pathology was discussed. After careful consideration of this proposal it was moved that the Tuberculosis Committee disapprove the use of 14x17 x-ray equipment on the mobile survey units operated by the State Board of Health and that they approve the use of 4x10 x-ray film in follow-up proceedings. This motion was carried unanimously.

The report was forwarded to the Executive Committee of this association for consideration. That committee expressed the opinion that a fee of $6.00 might be considered fair in view of present costs and in view of the fact that the survey is being rendered for indigent and near indigent persons and suggested that a number of the radiologists in Montana be consulted for their opinion. A poll of the radiologists indicated that five favored a fee of $6.00; two, $5.00; and two, $7.50.

After President Fredrickson placed this report on file, Dr. J. J. Malee moved that this association recommend a fee of $6.00 for 14 x 17 chest x-ray when the fee for such service is paid for by the Montana Tuberculosis Association for patients determined by their physicains to be indigent or near indigent. After discussion this motion was severally seconded and carried.

In the absence of Dr. B. C. Farrand, Jordan, Chairman of the Rural Health Committee, the following report of this committee was read by Dr. W. G. Tanglin of Polson:

Since the meeting of the state association last July, this committee does not have much to report. The chairman has requested that each member of the committee attend and take as active a part in all health meetings as they can so that each will be in a better position to formulate ideas of his own about how this committee can do the most

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Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being."

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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good and to give suggestions and advice to the state association. We did not have any representation at the national conference on rural health this year. The conference was held in Memphis and the chairman expected to attend the meeting, but because of bad weather and some irregularity in plane schedules, he was unable to attend. Hence we do not have a report of that meeting to present, but hope to have the report for the annual meeting in September.

No definite arrangements have been made for the combined meeting of the Montana Public Health Association, the Health Planning Committee and the Rural Health Committee as yet, but we will see that the membership of the association is given notice of this meeting in time for members to plan attendance. We hope that the representation of the state association will be large.

This report was placed on file. It was moved by Dr. Tanglin that this association endorse and encourage its members to attend the joint meeting of the Rural Health Committee, the Montana Public Health Association and the Health Planning Committee of Montana. Motion was seconded and carried. Following the approval of this motion it was moved by Dr. Tanglin and severally seconded that the Rural Health Committee of this association be authorized to invite a speaker to address the joint meeting of the Montana Public Health Association and the Health Planning Committee of Montana and that an amount of not more than $150.00 be appropriated to reimburse this speaker for his traveling expenses. Motion carried.

Dr. F. R. Schemm, Great Falls, Chairman of the Rheumatic Fever and Heart Committee, presented the following report:

This committee of the state association was formed in 1946 "to study problems related to the care and treatment of rheumatic fever and disorders of the heart and to cooperate with federal and state agencies interested in these conditions." After much study and investigation it made its first report and recommendations to the House of Delegates in June, 1948. The report was then sent to each member of the medical association for its consideration and in January, 1949, the House of Delegates endorsed the report as well as the following recommendations: (a) The inauguration in Cascade County of a pilot program for children under the age of 21 for consultation and diagnostic service and, for those unable to pay, hospital or convalescent care; and (b) The formation of local, county or state affiliates of the American Heart Association with professional participation. By January, 1950, the Great Falls area affiliate of the American Heart Association had received its charter and participated in the national campaign of February, 1950. The Cascade County Medical Society had endorsed the pilot program and established the necessary committees, including an advisory committee of general practitioners to see that no abuses crept into the program. Negotiations, however, with the cooperating federal and state agencies had not been concluded because of budgetary and personnel difficulties. The House of Delegates in January, 1950, again expressed its approval of the program. Final negotiations by all the parties concerned were concluded in April, 1950, and at the meeting of the House of Delegates on July 9, 1950, your committee was able to report that the first two clinics under the pilot program had been held in June.

1. **Interim Report on Cascade County Rheumatic Fever Pilot Program.** In its eight and one-half months of operation since June, 1950, fifteen clinics have been held. Fifty-three new patients were seen and sixteen follow-up examinations were done; a total of sixty-nine clinical examinations. Of the fifty-three new patients, forty-four were referred directly to the clinic from practicing physicians in the community and the nine others were referred by the practitioners to whom they had been sent by the school physician as a result of findings at a school examination. Eighteen different practitioners referred these patients and the referrals came from seven different medical groups as well as the individual practitioners. An analysis of the income groups involved showed that five of the fifty-three patients were on welfare rolls, twenty-seven were classified by the Welfare Department as belonging in the marginal income group and twenty-one were from the group with a higher than marginal income. All twenty-one of these latter were referred directly to the clinic by their family physicians. In accordance with the recommendation of the Cascade County Pilot Program Committee, all of the fifty-three patients were referred back for management to the doctors who had sent them with letters from the clinic director. In five cases so far, where diagnosis could not be adequately established in the outpatient clinic, hospitalization was carried out for further observation.

As recommended by the American Heart Association, standards for rheumatic fever and heart disease clinics include the following: The physician's history and physical examination, a fluoroscopic examination by a radiologist, an electrocardiogram, a urinalysis, a complete blood count and sedimentation rate. Prior to these studies the district nurse visits the home and obtains a social-economic and general history. After these studies the adult accompanying the child is counseled by a nutritionist and, in some instances, with the cooperation of the referring physician, arrangements have been made with the school nurse or teacher for rest periods and for the avoidance of stair-climbing and modification of physical activities. Arrangements for a visiting teacher are pending and it is hoped to make antistreptolysin titer determinations available.

The following is a brief analysis of the findings in the fifty-three patients examined in the eight months of operation: No disease present, 9; nonspecific infection present (no rheumatic fever), 8; rheumatic heart disease (no active rheumatic fever), 12; active rheumatic fever, 18; non-rheumatic cardiac disease (congenital), 6. The last category is of interest in view of the hopeful outlook in certain forms of congenital heart disease.

The federal and state funds made available for the pilot program and administered through the State Board of Health have been used very economically for part-time help from the local City-County Health Department and for the part-time services of a director. In the short period of operation no severe acute cases have been hospitalized for care as provided in the program for patients who are unable to pay as determined by the County Welfare Service. Convalescent care for indigent patients or patients who cannot be handled at home has not yet been arranged, but is under study. As the work increases those physicians of the community who express interest in the work of the clinic will participate in rotation and will receive a stipend for their help.

2. **Report on the Formation of American Heart Association Affiliates.** The Great Falls Area Affiliate has been organized and has operated slightly over a year. It has provided professional speakers for interested lay groups, well-attended courses on cardiac diets and on work-saving factors in the home. Its 1950 and 1951 local campaigns have raised a net of nearly $1,500 each year, after deducting 25 per cent for the national headquarters. The public, which had been pressing us hard in former years to do something about heart disease, seems to appreciate the cooperation of the local profession in these activities. The Southwest Montana Affiliate in Butte has its charter and has just participated in the February, 1951, national campaign. It is hoped that other affiliates are in the process of formation and that they will, with the profession cooperating, exert a good effect on our public relations.

3. **Report of the Committee on Possible Future Activities.** (a) Your committee, in accord with its recommendations of 1948, approved in 1949, for the overall program for the state, has discussed the advisability of recommending the start of another rheumatic fever clinic and program in the state if funds can be obtained. It would probably be best to wait and observe more than the eight months' operation now completed by the pilot program in Cascade County, except that negotiations often take a year or two before a start can be made on a new project. (b) The committee is also exploring possible ways and means of providing care for indigent patients with congenital heart disease.

Your committee recommends to the House of Delegates that (1) it approve the encouragement by the profession of the formation of other American Heart Association affiliates in suitable areas of the state and that it approve the active participation of the profession with laymen in these affiliates; and (2) that it approve the activities of its pilot program for rheumatic fever and heart disease in Cascade County and the work of the committees of the Cascade County Medical Society concerned with this pilot program.

There being no objection, the report was placed on file by President Fredrickson and the recommendations of the committee acted upon separately. Dr. R. D. Weber, Missoula, moved that the House of Delegates approve and en-

courage the profession to form additional affiliates of the American Heart Association in suitable areas of the state and endorse the active participation of members of the medical profession with interested laymen in these affiliates. This motion was seconded and carried. Dr. Weber then moved that the House of Delegates approve the Pilot Program for Rheumatic Fever and Heart Diseases in Cascade County and the work of the committees of the Cascade Medical Society concerned with this Pilot Program. This motion was seconded and carried.

President Fredrickson then presented Mr. Harvey T. Sethman, Executive Secretary of the Colorado State Medical Society, and asked him to report upon the Rocky Mountain Medical Conference to be held in Denver, May 9-11. Mr. Sethman reviewed briefly the scientific program to be presented to the Conference and urged physicians to plan to attend it.

Dr. John H. Bridenbaugh, Billings, who had been appointed by President Fredrickson to represent this association at a meeting of the American College of Radiology, was then asked to present a brief report of this meeting to the delegates. Dr. Bridenbaugh pointed out the need for the organization of definite plans for defense against atomic attack. He stressed the need for mobilization of Montana physicians so that they might be able to extend medical assistance in the treatment of those injured in neighboring states who might suffer from atomic warfare. Dr. Bridenbaugh reported that the Armed Forces Institute of Pathology had much information available on civilian defense and suggested that component societies might borrow this material and information for presentation to their members.

The House of Delegates recessed for luncheon at 12:00 noon.

At 2:00 p.m. the House of Delegates reconvened in the Rathskeller of the Placer Hotel, Helena.

The following report of the Industrial Welfare Committee was presented by Dr. R. B. Richardson, Great Falls, Chairman:

I have just returned from the Eleventh Annual Congress on Industrial Health held in Atlanta, Georgia. I shall not make any attempt to report on the full meeting, but only on those parts which seemed to me to be outstanding. A significant discussion was held on the screening program carried out by the Georgia Department of Health. It sent screening teams composed of technicians into industrial plants. Reports of their investigations were made to the medical members of the State Board of Health. The following tests were made: Height and weight; miniature chest film; a blood test for sugar; oral examination, including teeth; and urinalysis. These tests cost Georgia's Health Department $1.36 per person. Seventy-two per cent of the population, where the tests were made, took the tests and it is expected to cover the whole state of Georgia in this same manner.

Abnormal findings were reported to the designated family physician and the patient was referred by the Georgia Department of Health to the family physician. Doctor Petrie, the head of the Georgia Department of Health, is very pleased with the case findings and statistical results to date.

The other discussion which was of interest related to the plans which are being formulated on civil defense in industry in case of a bombing catastrophe. These plans were in the process of development and the speaker outlined what the committee, which had been appointed by the President, had decided up to date. It is recommended that in whatever localities industrial plants of any size are located with a physician in charge, that this physician correlate his plans for first aid to any injured people in industry with those of the civilian defense committees in his community.

The other phase of my report has to do with our relationships with the Industrial Accident Board. It is to be remembered that the recent chairman of the Industrial Accident Board had made several recommendations at various times. One recommendation related to the length of time that an injured person may be treated. He felt that any injured person should be treated until he had made as complete a recovery as possible and that there should be no limit on the time set for treatment of the injured people under the Industrial Accident Board; also, there should be no limit to the medical expense, except that covered in the fee schedules. In the final report of the Industrial Accident Board for the year 1950, the chairman also states that he is very interested in a Rehabilitation Center for clients of the Industrial Accident Board. I think that the Montana Medical Association should go on record as favoring alteration in the Industrial Compensation Act so as to remove the limit on the time that an injured person may be treated under the Industrial Accident Board expense and that there be no limit to the medical expenses allowed.

The American Medical Association has been very interested in recent years in holding industrial welfare conferences in various states. I feel that considerable good can come from such group gatherings. These conferences should be in the form of panel discussions which include industrialists, working men, the public health personnel, the Industrial Accident Board members and the medical profession.

This report was placed on file and the recommendations of this committee were then acted upon separately. Dr. Richardson moved that the Montana Medical Association write a letter to the Chairman of the Industrial Accident Board stating that this association favors the amendment of the Workmen's Compensation Act to provide complete coverage for injured industrial workers, with no limit upon the length of time such workers may receive treatment of their injuries; and that there be no limit to the amount paid by the Industrial Accident Board for medical care in the treatment of such injured persons. This motion was seconded and carried.

It was then moved, seconded and carried that the Montana Medical Association agree to actively participate in the planning of an Industrial Welfare Conference in this state.

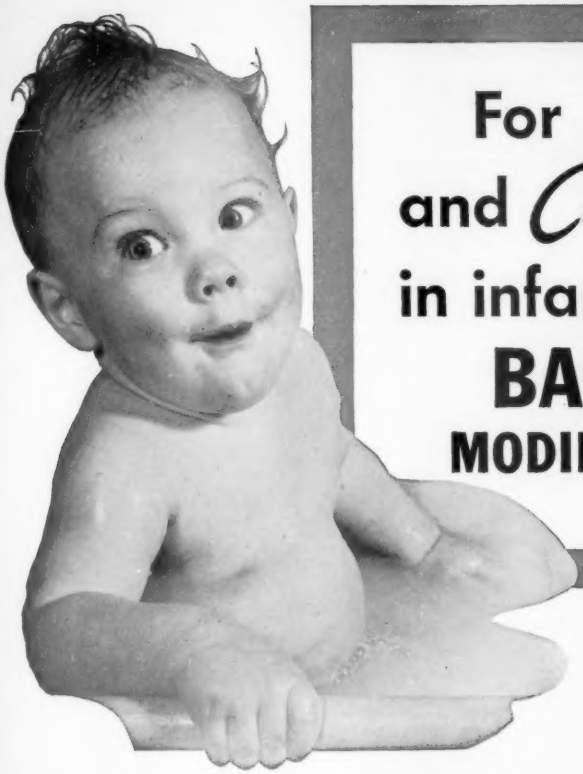
Dr. David J. Almas, Havre, presented a brief report on behalf of the Industrial Accident Board Committee. Dr. Almas informed the members of the House of Delegates that a short time ago the Industrial Accident Board announced an increased fee schedule. He also reported that his committee had suggested the appointment of a medical referee to the Montana Industrial Accident Board and that the board had agreed to consider such an appointment.

There being no recommendations by this committee, President Fredrickson placed the report on file.

President Fredrickson then asked Dr. F. S. Marks, Billings, Chairman of the Mediation Committee of this association, to present the report of that committee, as follows:

Members of the House of Delegates will recall that at the last annual meeting in Bozeman during July, 1950, an amendment to the By-Laws was adopted, providing for the establishment of a Mediation Committee. In adopting this amendment to the By-Laws, the Mediation Committee was instructed by the House of Delegates to prepare rules and regulations for the operation of the committee and to submit them to the Council and to the House of Delegates for final approval.

Your Mediation Committee has prepared the rules and regulations in accordance with the instructions and will distribute a copy to each delegate. (The rules and regulations were then read and reviewed carefully for the information of each delegate.) It is suggested that the House of Delegates approve these rules as prepared by the Mediation Committee. Some changes will be needed as experience may indicate. Your committee, however, believes that the proposed rules provide adequate principles to govern the operations of this committee.



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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

This report was ordered placed on file by President Fredrickson, there being no objection. Dr. H. W. Gregg, Butte, acting as Secretary of the Council of this association, then presented the following report:

After a joint meeting of the Council and Mediation Committee, your Council, in executive session, carefully reviewed the rules and regulations prepared by the Mediation Committee to govern its proceedings. It is the recommendation of your Council that this House of Delegates accept the report of the Mediation Committee and that the rules and regulations as proposed by that committee be approved and accepted.

It was moved by Dr. George G. Sale, Missoula, and seconded by Dr. G. M. Donich, that the report of the Council be accepted and the rules and regulations to govern the proceedings of the Mediation Committee as proposed be adopted.

After a full discussion it was moved by Dr. W. F. Cashmore and seconded, that the proposal of the Mediation Committee be recommitted to that committee in order that legal counsel and advice might be obtained. Motion carried.

Dr. Donich moved that the House of Delegates of this association vigorously support the economy program of Senator Byrd and urge Congressmen from Montana to support efforts to balance the budget of the United States by reducing non-defense expenditures so that American freedom will be preserved and the nation redeemed from tax accomplished socialism. This motion seconded and unanimously carried.

The following resolution was then presented by Dr. W. E. Harris, Missoula delegate from the Western Montana Medical Society:

Whereas, Frank David Pease, M.D., began the practice of medicine in Missoula in 1905 and practiced clinical medicine and pathology until he retired in August, 1948, and

Whereas, Charles Ralph Thornton, M.D., practiced medicine and surgery in Missoula from 1918 until he retired at the close of 1946, and

Whereas, Allen Richard Foss, M.D., practiced medicine in Missoula from 1922 until he retired from practice and from the Chief Surgeonship of the Northern Pacific Hospital in January, 1948, and

Whereas, These doctors have at all times been members in good standing of the Western Montana Medical Society and of the Montana Medical Association; therefore be it

Resolved, That the Western Montana Medical Society request the Montana Medical Association to elect Dr. F. D. Pease, Dr. C. R. Thornton and Dr. A. R. Foss honorary members.

Dr. Harris moved and Dr. R. D. Weber seconded that this resolution be adopted and that Dr. Pease, Dr. Thornton and Dr. Foss be elected to honorary membership. Motion carried.

Dr. Harris then presented the following resolution and moved its adoption:

Whereas, The Principles of Medical Ethics of the American Medical Association states in unqualified terms that it is unethical for a physician to derive profit from the sale of drugs or appliances, and

Whereas, The Montana Medical Association has adopted a similar code, to wit, "that it oppose the establishment of physician-owned clinic pharmacies as not only grossly unfair to pharmacy and pharmacists, but also as certain to result in resentment upon the part of pharmacists at the very time when conditions are such as to make imperative the utmost cooperation and friendliness between medicine and pharmacy and does condemn physician-owned clinic pharmacies as unethical, unwarranted and detrimental to good medical and pharmaceutical service." Now therefore, be it

Resolved, That the Western Montana Medical Society hereby affirms its belief in these ethical considerations and gives them support by respectfully requesting that its members avoid adverse publicity such as we judge to be the inevitable result of neglecting either the letter or the spirit of our code. Such neglect would reflect the entire profession in an unenviable light, as well as rouse specific question as to the motive of those responsible; and be it further

Resolved, That a copy of this resolution be presented to the House of Delegates at the Interim Meeting of the Montana Medical Association by our delegates at Helena, March 16-17, 1951, and that a copy of this resolution be sent to the Board of Trustees of the American Medical Association, the Retail Druggists Association of Missoula and the Montana State Association of Retail Druggists.

After the motion to adopt the resolution was seconded, several delegates spoke in opposition to it, inasmuch as a similar resolution had been adopted by the House of Delegates last July and inasmuch as the terms of the proposed resolution were rather general and uncertain. The motion to adopt this resolution failed to carry.

The following resolution was then presented by the Secretary-Treasurer, Dr. E. H. Lindstrom:

Whereas, E. H. Lindstrom, M.D., of the MPS Claims Committee, has recommended that an advisory committee from the various county medical societies be invited to meet with the MPS Claims Committee once each month, and

Whereas, The MPS Board of Trustees, at its meeting of Dec. 30, 1950, concurred with the recommendation of E. H. Lindstrom, M.D.; now therefore be it

Resolved, That this Board of Trustees hereby recommends to the House of Delegates of the Montana Medical Association that each of its constituent county medical societies elect from among its members a representative to act as a liaison officer between such county medical societies and the Board of Trustees of Montana Physicians' Service; that the duties of such liaison officer shall be as follows, to wit:

1. To, at the discretion of the local county medical society, attend meetings of the MPS Claims Committee held each Tuesday at 1:00 p.m., in the City of Helena, State of Montana, and
2. To receive complaints and/or recommendations from the local county medical society and transmit the same to the Board of Trustees of MPS, and
3. To serve as a contact officer between the employees of Montana Physicians' Service and the local county medical society.

That immediately upon the election of such a liaison officer by the local county medical society, the name of said liaison officer shall be transmitted to the office of the MPS and the Board of Trustees of MPS.

It was moved, seconded and carried that this resolution be approved and component societies asked to appoint such a liaison officer.

After announcing that it would be necessary for the House of Delegates to convene at noon, Saturday, March 17, for final consideration of the proposed amendments to the By-Laws, this session of the House was recessed at 3:45 p.m.

The last session of the House of Delegates was called to order by President C. H. Fredrickson at 11:45 a.m., Saturday, March 17. The Secretary-Treasurer called the roll and announced that more than a quorum was present.

The Secretary-Treasurer then read the proposed amendments to the By-Laws to create the office of Assistant Secretary-Treasurer. These proposals are as follows:

Under Article V, add after the words "the Secretary-Treasurer," "The Assistant Secretary-Treasurer."

Under Article VIII, Section I, paragraph (a), add after the words "the Secretary-Treasurer," "an Assistant Secretary-Treasurer."

Under Chapter IV, add the following new section: "Section 7. The Assistant Secretary-Treasurer shall be an ex-officio member of the Council, the House of Delegates and of all committees, but without the right to vote. He shall assist the Secretary-Treas-

urer in the discharge of his duties. In case of the Secretary-Treasurer's death, resignation, removal or inability to function, he shall serve as Acting Secretary-Treasurer and shall assume all of the duties of this office until the next session of the House of Delegates."

Dr. W. B. Cox, Missoula, moved and Dr. Malee seconded that these amendments be adopted. Motion carried.

Dr. Louis W. Allard presented a supplemental report of the Interprofessional Relations Committee for the information of the delegates. He announced that his committee had met with representatives of the Hospital Association, the professional nurses group and the practical nurses group to discuss means of certification of practical nurses. He indicated that several hospitals would cooperate in a program of training for practical nurses. There being no further business, the House of Delegates adjourned at 12:15 p.m.

The following delegates and alternates were present during the meetings of the House of Delegates:

Cascade County: F. L. McPhail, Great Falls; Dora Walker, Great Falls; F. D. Hurd, Great Falls; C. F. Little, Great Falls; R. B. Richardson, Great Falls, and F. H. Crago, Great Falls.

Fergus County: R. L. Eck, Lewistown, and P. J. Gans, Lewistown.

Flathead County: W. G. Tanglin, Polson, and J. W. Isgreen, Whitefish.

Gallatin County: D. C. Epler, Bozeman.

Hill County Medical Society: A. W. Axley, Havre, and D. J. Almas, Havre.

Lewis and Clark County: W. F. Cashmore, Helena; J. J. McCabe, Helena, and D. T. Berg, Helena.

Mount Powell County: J. J. Malee, Anaconda, and G. M. Donich, Anaconda.

North Central Montana: P. S. Cannon, Conrad.

Silver Bow County: H. J. Sannan, Butte; H. D. Rossiter, Sheridan; R. L. Casebeer, Butte; S. V. Wilking, Butte, and R. F. Peterson, Butte.

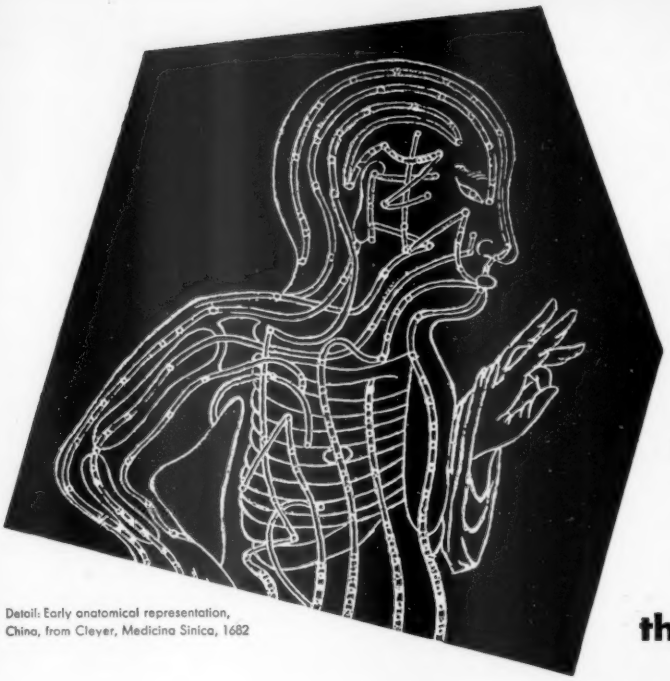
Southeastern Montana: S. A. Olson, Glendive, and R. D. Harper, Sidney.

Western Montana: W. F. Morrison, Missoula; W. E. Harris, Missoula; H. M. Blegen, Missoula; R. D. Weber, Missoula; J. M. Nelson, Missoula; W. B. Cox, Missoula; C. P. Brooke, St. Ignatius, and G. G. Sale, Missoula.

Yellowstone Valley: Louis W. Allard, Billings; R. E. Benson, Billings; D. E. Hodges, Billings; T. R. Vye, Billings; J. H. Bridenbaugh, Billings; L. G. Russell, Billings, and M. M. Gerdes, Billings.

GREAT FALLS CONFERENCE

The second annual Great Falls Medical-Surgical Conference will be held in Great Falls, June 25 and 26, 1951. Speakers already chosen for this year include Dr. Stanley O. Hoerr, Staff Surgeon of the Cleveland Clinic; Dr. John Parks, Professor of Obstetrics and Gynecology at George Washington University School of Medicine; Dr. R. V. Platou, head of the Department of Pediatrics at Tulane University; Dr. Stewart G. Wolf, Jr., Associate Professor of Medicine at Cornell, and Dr. D. A. Dowell, Assistant Professor of Radiology at Creighton University. The Cascade County Medical Society will be host to the Conference, as in 1950, and Dr. William E. Sullens of Great Falls is Chairman of the Program Committee.



Detail: Early anatomical representation,
China, from Cleyer, Medicina Sinica, 1682

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There is one—pathology—but it is difficult to name any other medical field in which thyroid is not prescribed at some time. While specific indications vary, all physicians agree that a standard stable preparation is desirable. 'Tabloid' brand Thyroid U. S. P. is such a preparation. As pioneers in the development of standardized thyroid medication, Burroughs Wellcome & Co. continues to provide a thyroid preparation of constant potency.

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NEW MEXICO
Medical Society

Leland S. Evans

Dr. Leland S. Evans of Las Cruces was installed as President of the New Mexico Medical Society May 3, during the Sixty-ninth Annual Session of the Society.

Dr. Evans was born May 20, 1909, in Bell County, Texas. He attended local schools and was graduated from the Temple High School in 1925. In 1929, he received his Bachelor of Arts degree from the University of Texas and in 1933 he received his Doctor of Medicine degree at the University of Texas Medical School.

His internship began at the John Sealy Hospital in Galveston, Texas, in 1933 through 1934, with the second year of internship spent in El Paso, Texas, at the El Paso City-County Hospital.

In 1935, he moved to Las Cruces and began active practice, being associated with the late Dr. R. E. McBride, one of the organizers and founders of the New Mexico Medical Society. This association continued until 1942 when he entered active military service.

Three and one-half years were spent on active duty with the Army, serving in the Air Corps.

He is an active member of the Dona Ana County Medical Society, serving as President in 1937-1938, and as Secretary from 1946 through 1950. He served as a member of the Council of the New Mexico Medical Society from 1946 to 1949. He is a member of the American Academy of General Practice.

He has been a member of the Lions Club at Las Cruces since 1935, serving as President in 1937-1938.

Obituary

LEO B. COHENOUR

Leo B. Cohenour, M.D., Albuquerque, died April 25, 1951, at his home of a heart attack. Dr. Cohenour was born in 1891, and was a graduate of the University of Colorado in 1918.

Dr. Cohenour was active in the medical profession in Albuquerque for thirty-two years, and served as Secretary of the New Mexico Medical Society for eighteen years. He was a Fellow of the American College of Surgeons and a Fellow of the American Medical Association. During World War II he was in charge of procurement and assignment for the Army Medical Corps in New Mexico.

Dr. Cohenour served in World War I with the Navy. He was active in Masonic bodies, being a member of Albuquerque Lodge No. 60, A. F. and A. M., York Rite, Ballut Abyad, Temple of the Shrine. He was also a member of Hugh Carlisle Post of the American Legion, and of the Albuquerque Country Club.

NEW MEXICO MEDICAL SOCIETY
Annual Committee Reports

Basic Science Committee

A meeting was held in Santa Fe November 4, 1950. Dr. Raymond Young, Chairman of the committee last year and member of the Basic Science Board, was also asked to attend.

The report made by the committee at the last state meeting was reviewed. Most of the groundwork for the following suggested changes in the Basic Science law was done by last year's committee.

1. The fee for examination should be raised to $50, and the fee for re-examination within one year should be $25. The fee for license by reciprocity, or re-examination after one year should be raised to $50. The reason for this increase in fees is to give the board sufficient income to employ a full-time lay secretary.

2. The office of the full-time lay secretary should be in the State Capitol Building.

3. The hiring of the lay secretary by the Secretary of State should be subject to the approval of the Basic Science Board, and provision should be set forth for discharging her at the discretion of the board.

4. The place of examination should be specified to be some place not connected with the healing arts.

5. The frequency of examination should be specified, and we suggest that they be held quarterly.

6. It is suggested that special examinations be abolished.

7. The question of waiving examinations for doctors employed in state institutions was discussed, and disapproved in principle. We felt that this matter should be referred to the legislative committee with the following suggestions:

a. If they are allowed a waiver of the Basic Science examination while employed in a state institution, they should be required to take the examination before they are eligible for license by the State Board of Medical Examiners.

b. That the State Medical Society and the State Board of Medical Examiners, and the Basic Science Board disclaim any responsibility as to qualifications of these men.

V. E. BERCHTOLD, M.D., Chairman.

Board of Supervisors

Your Board of Supervisors wishes to thank the physicians of the Society for their cooperation in making the board effective both as to helping improve public relations in a general way and specifically in the way the physicians against whom complaints have been lodged have responded to recommendations of the board. Our Society was about the twelfth of the thirty-four that have Grievance Committees to get such a committee or board of supervisors (as ours is called) to functioning. In summary, the following is an outline of our board's duties and powers:

"The board investigates and supervises the ethical deportment of the membership of the Society, makes periodic recommendations for improvement of professional conduct, and may prefer and prosecute charges before the appropriate judicial bodies against any physician deemed by the board to be guilty of unprofessional conduct. However, it does not have final jurisdiction or the authority to discipline a physician (grand jury power).

"Complaints are received from any lay or professional person, and an informal investigation is first conducted either by the board as a whole or one or two members designated by the chairman. If no disciplinary action is indicated by such investigation, and both complainant and physician are willing to accept the advice of the board, the matter may be considered as settled—(This is the way about half of the cases that have come to the board have been settled). If the board is unable to reconcile differences over fees charged by a Society member, it may determine by a majority vote the fee it deems fair and proper. Should the physician agree to this fee and then fail to abide by it, he will be cited before the Board of Councilors for contempt proceedings. If he does not agree to the fee, charges of unprofessional conduct may be filed.

"When informal investigation indicates disciplinary action, the entire board, with the exception of the member whose county is involved, considers the matter formally and further action is determined by majority vote. The board may file charges with a county Board of Censors, the councilor of the appropriate district, the Board of Councilors, the

State Board of Medical Examiners, or any criminal court."

The following is a breakdown of the twenty-two complaints against twenty New Mexico physicians in ten New Mexico communities that have come before the board during its eighteen months of existence:

	SETTLEMENT			
Fees	Favor Pt.	Favor M.D.	Pending	Referred
Ob. ----------2				
Surg. ----------6				
Med. ----------4—13	4	7	2	--
Ethics and Professional Conduct 6	4	2	--	--
Professional Competence -------- 1	1	--	--	--
License Deficiencies--- 2	--	--	--	2
Totals ----------22	9	9	2	2

Thus it can be seen that the board functions equally as much to protect the physican against unjust accusations as to protect the public from unscrupulous or unethical members of the profession.

Our board would like to make the following general recommendations:

1. The physicians make it a practice to have a clear understanding with each patient concerning the charge for services to be given.
2. That he be certain the charge is just before turning a delinquent account over to a collection agency and try to learn if patient is financially able to pay regular charges.
3. That time, responsibility, service rendered, and value patient feels the service has been to him and patient's ability to pay, all be considered.
4. That we all make it a point to periodically check ourselves on principles of ethics and professional conduct we are to follow.

C. PARDUE BUNCH, M.D., Chairman.

Cancer Committee

The activities of the Cancer Committee were seriously handicapped in 1950 by the untimely death of Dr. Cranford H. Douthirt of the Health Department, Chief of the Cancer Division, and the failure of the American Cancer Society, New Mexico Division, to raise enough funds to meet the 1951 budget. An agreement had been worked out with the Health Department, under Dr. Douthirt's direction and with the New Mexico Cancer Society, whereby certain diagnostic and laboratory costs would be defrayed from Department of Health funds allocated to this division and the funds from the Cancer Society would be used in assisting medical-indigent patients suffering with cancer to obtain necessary treatment. Failure of the annual campaign to raise sufficient money for the New Mexico Cancer Society sharply curtailed this program.

At the present time there are five cancer detection centers in New Mexico. They are: Aztec, San Juan County; Carlsbad, Eddy County; Clayton, Union County; Los Alamos, Los Alamos County; Santa Fe, Santa Fe County. The Health Department reports some difficulty in obtaining reports of cancer cases as required by law from physicians. In general, the reporting of these cancer cases by clinics has been good. Through the courtesy of the New Mexico Department of Health the reported cases of cancer from 1946 to 1950 are shown in the enclosed table.* The number of reported cases has increased each year, but on the basis of these reports it cannot be said that there has been an absolute increase of cancer in the State of New Mexico for the period reported.

MURRAY M. FRIEDMAN, M.D, Chairman.

*Not reproduced here.

Committee on Diabetes Detection

Prior to the drive in November all the County Medical Societies were contacted by mail and they were sent the necessary forms to request publicity information, literature, posters, and drugs for urine tests from the American Diabetes Association in New York City. Following this drive, all the societies were again written to and were asked to advise me by mail as to the outcome of their programs.

In reviewing the work done, I think that for the most part the drive was successful. Six of the sixteen counties did not reply to the two letters the committee sent to them. I would urge that at the coming state meeting the delegates be advised of this fact that your committee cannot function properly without the unified support of each county society.

BENJAMIN BARZUNE, M.D., Chairman.

Of Special Interest to General Practitioners and Specialists

Fifth Annual

Rocky Mountain Cancer Conference

DENVER • COLORADO

July 11 and 12, 1951

Eight Distinguished Guest Speakers

W. Edward Chamberlain, M.D., Philadelphia.....Radiology
Oscar T. Clagett, M.D., Rochester, Minn.....Surgery
G. Edmund Haggart, M.D., Boston.....Orthopedics
John H. Lamb, M.D., Oklahoma City.....Dermatology
Walter L. Palmer, M.D., Chicago.....Internal Medicine
John Rock, M.D., Boston.....Gynecology
Frank B. Queen, M.D., Portland, Oregon.....Pathology
Robert A. Scarborough, M.D., San Francisco.....Proctology

ROUND-TABLE DISCUSSION

NON-SCIENTIFIC BANQUET

For Hotel Reservations, Write to Cancer Conference, 225 West Colfax, Denver, Colorado

NO REGISTRATION FEE

Sponsored by Colorado State Medical Society and Colorado Division, American Cancer Society

Advisory Committee on Insurance Compensation

It has come to the attention of the committee that there is much irregularity in testimony presented in the courts. The committee has undertaken an investigation of the way this matter is handled in other states. Considerable progress has been made in the East and Middle West. One of the best plans we found was that in which the State Medical Society set up a so-called "Medical Testimony Committee" to cooperate with the court and the Bar Association. This committee reviews the testimony when complaints are made about irregularity, and when it finds there are grounds for such complaints, the persons involved are informed, and in most instances the problem is cleared up. It is our belief that such a committee could operate in conjunction with the Medical Board of Supervisors. The Advisory Committee on Insurance Compensation would like to present this recommendation for your consideration.

The committee recommends that the State Society use its influence with the State Legislature to make changes in the State Compensation Act. There are sections in the act which are confusing to the members of the medical profession and cause them to spend needless time in court. There should be a Compensation Commissioner to review cases and obtain adequate correct information for reaching decisions, and it would be well to consider a Medical Board to assist him.

LEWIS M. OVERTON, M.D., Chairman.

Committee on National Emergency Medical Services

This committee in January, 1949, presented to Governor Thomas Mabry and to the New Mexico Medical Society a tentative major disaster plan for the communities in New Mexico. This plan was approved by the Council on National Emergency Medical Services of the A.M.A. It was an outline, basic plan for mutual assistance, of organization, of definition of essential functions, of supplies and of liaison with outside agencies such as the American Red Cross, federal agencies, and other state organizations as fire, police, transportation, etc. It indicated that future medical plans eventually will include measures to minimize the effects of biological and chemical warfare, as well as those of atomic warfare. No official action was taken by any state authorities and the chairman was advised by the Governor to hold this medical plan in abeyance. Therefore, the chairman advised the House of Delegates, in May, 1950, that individual, interim plans be initiated in local communities under the leadership of county medical societies.

In 1950 the activities of this committee, which also is the State Medical Advisory Committee for New Mexico Department of Civilian Defense, were chiefly concerned with two aspects of advancing the state medical plan for civilian defense. The first was greatly detailing and enlarging on the above-mentioned basic outline plan. This was done in accordance with advance information in May, 1950, and approval of the Council on National Emergency Medical Service of the A.M.A. The administrative and combat experience of the chairman in carrying out similar war-time plans were incorporated in this plan. Ideas from several other states were also incorporated. Therefore, our committee's medical plan of June, 1950, had the details and principles which were later published in "The Federal Master Medical Plan," at the end of 1950, by the Federal Civil Defense Administration, in the publication, "Health Services and Special Weapons Defense." Copies of this book were mailed to all county medical societies and all community medical civil defense chairmen by the chairman. On July 14, 1950, the chairman presented our committee's Medical Plan for Civilian Defense in New Mexico to the newly-appointed State Medical Director, Dr. James R. Scott.

After nine months very few of our committee's recommendations presented on July 14, 1950, have been carried out. This is chiefly due to the lack of a trained civil defense assistant to the State Medical Director, and shortage of medical personnel on his staff which has not been rectified but contrarily made worse by the death of Doctor Douthirt and the resignation of Doctor McIntyre, with no replacements to date.

There is at present no adequate information source in the office of the State Medical Director for the continuous process of authoritatively answering the many questions from various parts of the state on medical civilian problems and continuous coordination, in a consecutive manner, at state level, of authoritative information and policies.

There has been made a rough inventory of certain essential medical supply houses. This revealed a meager supply of needed items for large scale needs of atomic disaster. Regional stock piles of these items should be available as soon as possible. These will come from the federal government and from

state civil defense sources. Local hospitals should moderately increase their inventories of these essential items. It is hoped that the American Red Cross will give limited assistance in supplying certain items needed in local blood bank and local blood typing programs.

Nurses and members of the staff of the New Mexico State Director of Public Health have attended courses in Medical Aspects of Atomic Warfare. They will act as lecturers and demonstrators with aid of motion picture films in two-day Institutes on Nursing Aspects of Atomic Warfare held in fourteen communities in New Mexico during March and April.

The American Red Cross first aid instructors have arrived in New Mexico and courses for instructors are being held. The local instructors are to train an estimated 20,000 people in New Mexico. In many communities this program has been far advanced.

The so-called Federal Master Medical Plan as published is so comprehensive that most communities in New Mexico will not need nor can we afford to carry out all of the provisions detailed in this publication. Many of these provisions must be modified to fit the needs and limitations found in New Mexico. It is recommended that local community medical directors and county medical societies should use "Health Services and Special Weapons Defense" as a guide in formulating and implementing community and district civilian defense medical plans and as a guide in relations of local plans to statewide planning until the time when the State Medical Director will establish coordinated, consecutive policies and principles for New Mexico. The recent many questions arising about a state-wide blood typing program points up the need for a well-defined policy at state level. A limited, long-time program of blood typing by picked technicians and mobile teams might answer some of the objections by many national medical authorities to hurried mass blood typing and eliminate dangers of probable technical errors in mass programs.

In August, 1950, the regional representative of the National American Red Cross came here from St. Louis for a meeting and promised that New Mexico would have a blood bank for State Civil Defense needs. At another meeting in Albuquerque in November, 1950, another American Red Cross representative informed New Mexico Medical Society officers, New Mexico Civil Defense officials and the chairman that the delay in accepting this blood bank and lack of funds (due to the war in Korea) caused a withdrawal of the establishment of a blood bank in New Mexico. A promise was made that blood would be sent to New Mexico by air from near regional blood banks in the event of atomic disaster.

It is emphasized that the New Mexico medical civil defense plan will progress at a better pace when the recommendations of this committee are carried out. These were presented to Governor Mabry and to General Sage in November, 1950, by the chairman in person and again to Governor Edwin Mechem in a personal interview of February 15, 1951, and again in a letter to the Governor (with a copy to General Sage) on April 9, 1951. The recommendations are here summarized: That a full-time assistant be given to the State Medical Director, a physician experienced and trained in modern major medical disaster planning and organization and that adequate funds be provided that he may also travel as a field representative to stimulate continuing interest by community medical civil defense personnel and to assist local organizations; funds should be provided for pertinent literature for education programs and implementing certain special training programs of key medical personnel (not provided by the federal program), and funds for the purchase of supplementary medical supplies and certain equipment, educational and training aids, such as motion picture films, not provided by the federal program nor by federal regional stock piling.

Several members of this committee have been present at some of the meetings held in the office of the State Medical Director in Santa Fe during the first few months after July, 1950.

The second phase of activity by this committee was in the interests of obtaining official representation of organized medicine in the State Civil Defense Organization. After the appointment of the chairman in 1948 by President Travers of the New Mexico Medical Society and in 1949 by President Hannett, presentations of the interest of the New Mexico Medical Society and of the medical plan for civilian defense of our committee were first made to Governor Mabry late in 1948 and again in January, 1950. The chairman, because of his residence in Santa Fe, has made himself available and has given much time (averaging once every week during 1950 and 1951) when called upon either by General Charles Sage, the State Director of Civilian Defense, or by Mr. Edward Oakley, the Assistant State Director, or by Dr. James R. Scott, the State Medical Director, or by the Governor's office. It is hoped these fre-

quent calls upon the chairman's time and absences from his practice will decrease in the future.

It is known that the Korean war and a directive by President Truman finally stimulated interest in a State Civilian Defense Program and in July, 1950, Governor Thomas Mabry appointed the above-named officials. In addition, Governor Mabry, in July, 1950, appointed an eight-man Executive Committee of the New Mexico State Council of Civilian Defense, "with over-all responsibility for seeing that New Mexico has a proper civilian defense setup" and to work under the State Director, General Sage. The chairman was the only physician appointed to this Executive Committee, and gave New Mexico Medical Society first official representation in the newly-established New Mexico Civilian Defense Department.

In August, 1950, upon the recommendation of President I. J. Marshall and of General Sage, the entire membership of the Committee on National Emergency Medical Service of the New Mexico Medical Society was appointed by Governor Mabry to serve as the State Medical Advisory Committee to the New Mexico Department of Civilian Defense. This gave a larger official representation to the New Mexico Medical Society.

In January, 1951, during the session of the New Mexico Legislature, House Bill No. 32, sponsored by Mrs. Ruth Taichert and other legislators, was introduced as the proposed Civil Defense Law. This bill followed model Federal legislation and was found to be too drastic and otherwise not acceptable to Governor Mechem and to a Legislative Committee. The present State Civil Defense Law and appropriations are much watered-down provisions of even the substitute bill. This is another important limitation, in New Mexico, to what could be a more adequate and more efficient civilian defense organization against atomic warfare.

On January 19, 1951, Dr. James C. Sargent, Chairman, Council on National Emergency Medical Service of the A.M.A., addressed a letter to the chairman emphasizing the need for an intensification of the civil defense training program in 1951, for the rank and file of doctors, hospital personnel, nurses and technicians. He suggested courses be organized by state and county medical societies and at hospital staff meetings, and he urged attendance at the federal, army, navy and medical school sponsored courses, in medical aspects of atomic warfare and special weapons defense.

It is hoped in the future months that state level authorities in civilian defense will match the example of local initiative and individual energetic action evident in several community civil defense organizations in New Mexico. Then we may be, eventually, ready to carry out adequately the major mission of the civilian defense organization, not to defend against attack, but to minimize greatly the loss of life, to minimize crippling by injuries and disability by diseases, on an unprecedented scale, if a destructive modern attack, atomic, biological or chemical, strikes one or more communities in New Mexico.

DR. ANTHONY E. REYMONT, Chairman.

Legislative Committee

This year during Legislature the experiment was tried of having a professional lobbyist, Mr. Paul Case, to keep us advised as to the progress in the Legislature of any bills in which we were interested.

H.B. 28, providing that doctors practicing in state institutions need not take the Basic Science examination, was passed with the amendment that this would also apply to industrial practice. I was not advised by Mr. Case that this amendment had been tacked on, but learned of it when the bill was on the Governor's desk for signature. After hurried consultation, I recommended that the Governor sign this bill for the sake of the state institutions.

S.B. 129, the Naturopath Bill, was killed in committee largely through the efforts of Johnnie Walker of Silver City.

S.B. 138, which provided for the payment of unemployment compensation through disability, died in the Judiciary Committee, of which Senator A. B. Carpenter was Chairman.

S.B. 182, defining the practice of osteopathy, died in the State and County Affairs Committee.

S.B. 211, the New Mexico Physicians' Service law passed and was signed by the Governor. This bill permits other insurance companies, in addition to Business Men's Assurance Company, to sell New Mexico Physicians' Service.

S.B. 231, relating to the practice of chiropractic, was given a "Do Not Pass" in the State and County Affairs Committee and was defeated in the Senate.

S.B. 253, changing the Basic Science Act, died in the Judiciary Committee, although it was urgently pushed by the Legislative Committee.

A. S. LATHROP, M.D., Chairman.

When Convenience is the Keynote

DEXTROGEN®

For Your Infant Patients

Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrins, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with 1½ parts of boiled water,* it yields a mixture containing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.

The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

NOTE HOW SIMPLE TO PREPARE

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed *

THE NESTLÉ COMPANY, INC.
COLORADO SPRINGS, COLORADO

WANTADS

OPPORTUNITY IS KNOCKING — Summitt County needs a doctor. The only doctor in Summitt County is retiring and will sell his ranch home and practice, located in the heart of the Rockies. No competition. Wonderful location for an M.D. Buck Realty Company, 1053 Broadway, Denver, Colo. TAbor 3336.

FOR SALE—New Westinghouse x-ray machine used less than six months. 100 kw-100 ma. Bucky, vertical and horizontal fluoroscopy. All accessories including large developing tank, three cassettes, lead apron, lead gloves, etc. Price $2,300 f.o.b. northern Texas. Reason for selling, ill health. Address c/o Box No. 6, Rocky Mountain Medical Journal.

Public Relations Committee

This report will outline the progress made on the objectives which were set up for this committee in May of 1949 and at subsequent meetings.

1. The Board of Supervisors has functioned continuously since October, 1949, and has apparently had a salutory effect on physician-patient relations. It is recommended that more widespread publicity concerning the existence of this board be obtained by ethical means.

2. More participation by doctors in their local community affairs is continuously being recommended through the News Letter and in County Society meetings.

3. Average fee schedules are under consideration by several County Societies, in most instances with the point in view of updating charges for average and usual procedures but with no definite intent of publicizing these fee schedules. This matter of publicity of average fee schedules should properly be one for local determination.

4. The second annual meeting of County Society officers was held in Albuquerque January 27, 1951. A successful afternoon and evening meeting was held with numerous guests from allied professions present. Following the evening banquet Dr. Austin Smith, Editor of the Journal of the American Medical Association, gave an address. All counties of the state except one were represented at this meeting. Following the return home of the County Society officers a questionnaire was sent out to obtain reactions to the meeting and suggestions for improvement of this meeting for the indoctrination of new officers, and the spreading of essential information concerning the year's activities is recommended in the future.

5. During the past year the field activity of elected officers of the State Society has been considerable and it is recommended that this procedure be continued in the coming year.

6. It is recommended that each County Society maintain a Public Relations chairman who is sufficiently acquainted with local news agencies and who possesses a sense of discretion in releasing news concerning medical activities in the community.

7. The activities of Mr. and Mrs. Ralph Marshall during the past year in the service of the New Mexico Medical Society have been exceedingly extensive and energetic and it is recommeneded that they be commended by the Society as a whole and encouraged to further efforts.

8. Continued cooperation with an encouragement of Women's Auxiliaries must be emphasized. The Women's Auxiliary held a meeting in Albuquerque at the same time as the County Officer's meeting during which time they were addressed by the President of the Auxiliary to the American Medical Association. Excellent work is being accomplished by these ladies and much more can be done by the cooperation of the local Medical Society. More joint meetings of Women's Auxiliaries of several adjoining counties should be held for a pooling of ideas and to show others how the job may be done.

9. It is strongly recommended that provision of a central telephone exchange to help patients locate their doctors or a doctor in case of emergency be considerd by all societies in medium and large cities.

EARL L. MALONE, M.D., Chairman.

Rural Health Committee

The Rural Health Committee of the State Medical Society has functioned throughout the year principally through the activities of its individual members. One meeting was held at midyear to discuss matters of concern to physicians generally throughout the state and particularly those interested in the problems of practice in rural areas.

At least twenty communities in the State have aggressively kept their need for a physician before the public and especially before the Secretary of the State Society. Of these areas at least a small number has been successful in securing the services of a Doctor of Medicine to care for the community needs. Cuba and Bernalillo in Sandoval Counties, Corona in Lincoln County, and Melrose in Curry County are among locations which have recently welcomed new physicians.

While the drift of doctors to Santa Fe, Albuquerque, Clovis, Roswell, Las Cruces, and other cities has continued, the near saturation point is being reached in the opinion of some observers. This may portend good things for the smaller communities as there is a considerable number of physicians outside the state who have indicated by their correspondence a desire to make New Mexico their home and seek opportunity to engage in active practice in the state.

An advertisement run in the Journal, A.M.A., for four weeks recently has resulted in about 150 inquiries. As the ad specifically sought men or women who would go into practice in rural areas, this was

a surprising return. As was to be expected, however, a large portion of these have made no further follow-up after learning of the licensing regulations. Some do not qualify for license, but a considerable number are either too old in their own opinion to try the Basic Science examination, or refuse to take more examinations, as they already are licensed in one or more states. They are somewhat resentful of their inability to get reciprocity.

There is reason to believe that at least five or six more areas now wihout physicians will have their needs met from this list of persons who answered the advertisement.

It is regrettable that during the past year at least four or five physicians who came into the State and located in rural areas have decided not to remain. A careful analysis of each of these departures has been made to ascertain what, if anything, the communities can do to hold physicians and make practice in the particular areas more attractive.

It can be said with assurance that the last several years have seen a rapidly mounting community interest in trying to secure physicians. Some areas have displayed outstanding interest. Recently the citizens of one area purchased x-ray equipment to make their health center more serviceable to any physicians who may consider that community for a location.

Close cooperation between the office of the Secretary of the State Society and many local community civic groups and with the office of the New Mexico Health Foundation has made possible clearance of the activity in all areas regarding the need for physicians.

The Rural Health Committee was not represented this year at the A.M.A. National Conference on Rural Health, it being felt that little assistance could thereby be gained in solving our problem here in New Mexico.

The committee must have the continuing support of all physicians in the state in its effort to establish ground for denial of the accusation one sometimes hears, that the doctors themselves are doing little to insure medical service to people outside the immediate trade zone of our cities.

To the many who have helped during the past year goes the appreciation of the committee.

To the best of our knowledge, the below listed communities are still in need of physicians. If you know of any additional communities that should be added to this list, or if any of the communities listed now have a doctor, will you please communicate with the State Office: Alamogordo, Aztec, Cimarron, Elida, Espanola, Hobbs, House, Jal, Las Cruces, Los Lunas, Madrid, Magdalena, Mora, Mosquero, Mountainair, Puerto de Luna, Reserve, Roswell, Ruidoso, San Jon, Vaughn, Wagon Mound, West Albuquerque.

STUART W. ADLER, M.D., Chairman.

Infancy and Maternal Care Committee

During the last war wives and families of enlisted personnel in the lowest four pay grades received specified amounts for obstetric care, namely, a flat fee of $50.00 to physicians for expenses of childbirth, including delivery, prenatal and postnatal care, and payment of hospital expenses.

At present, House Bill 3349 has been introduced in Congress and referred to the Committee on Armed Services. This bill provides that the wife of any member of the Armed Forces after the enactment of this legislation who incurs expenses in childbirth, shall be entitled to receive not to exceed $100.00 from the secretary of the service in which her husband is attached, if such is found to constitute an undue financial hardship. The bill will be administered by Military Service, and payment would be made to the service man's wife, rather than directly to the physician and hospital.

If a similar plan is activated for the present or future, the following recommendationss for improvement are offered.

1. Not to set a fixed fee for the doctor but to pay commensurate to what service the doctor renders.
2. To have a competent consultant on all operative obstetrics.
3. To have adequate funds for administration, if the Children's Bureau should have the administration of the plan again.

S. M. GONZALES, M.D., Chairman.

New Mexico Physicians' Service Report

Under prepaid medical care the physicians have the choice to lead, or be led. We in New Mexico elected to assume leadership. The choice was in many ways more difficult, but the profession has found it far more satisfactory.

The turbulent history of New Mexico Physicians' Service during its first four years is well known to most of you. It has been anything but dull—we are glad that we have it behind us.

This year we had a legislative problem. Our original physicians service enabling act made no provision for operating with insurance companies. We clarified the act at the last session of the Legislature to allow such operation.

We renewed the agreement with Business Men's

FOURTH ANNUAL

POSTGRADUATE ASSEMBLY

in

ENDOCRINOLOGY INCLUDING DIABETES

Sponsored by

THE ASSOCIATION FOR THE STUDY OF INTERNAL SECRETIONS

and

THE AMERICAN DIABETES ASSOCIATION

Seattle, Washington Olympic Hotel July 2-7, 1951

The faculty will consist of prominent researchers and clinicians in the field of endocrinology and metabolic disorders.

The course will be a practical one of interest and value to the specialist and those in general practice. The program will consist of lectures, clinics, and demonstrations. Ample time will be given to questions and answers at the end of each session, and registrants are encouraged to contact members of the faculty for individual discussions.

The Olympic, one of Seattle's most delightful hotels, offers special convention rates to members of this assembly. This is an unusual opportunity for you and your family to enjoy a pleasant vacation in the beautiful Pacific Northwest and for you to participate in a highly instructive program of the latest advances in endocrinology and metabolism.

A fee of $75 will be charged for the entire course and the attendance will be limited to 100. REGISTRATION WILL BE IN THE ORDER OF CHECKS RECEIVED AND WILL CLOSE ON JUNE 4, 1951. Should there be an insufficient number of applicants to fill the course, the registration fee will be refunded immediately in its full amount.

Please forward application on your letterhead, together with checks payable to The Association for the Study of Internal Secretions, to Henry H. Turner, M.D., Secretary-Treasurer, 1200 North Walker Street, Oklahoma City 3, Oklahoma, before June 4, 1951. Further information and program will be furnished upon request.

Hotel reservations should be made directly with the Olympic Hotel, Seattle, Washington, and the hotel advised that you are attending this Postgraduate Assembly.

Assurance Company. Graduated payments for the sale of New Physicians' Service by Business Men's Assurance will continue to be made. In 1950 they amounted to $14,074.47.

Used as follows:

Payments to California Medical Assn.	$4,500
Salaries	2,200
Travel and Meetings	2,493
Advertising Plan	2,141
Office Expenses	814
Old NMPS Claims	555
Legal Fees	153
Auditing and Bookkeeping	216
Bank Balance	1,072

Business Men's Assurance agree to a few increases in our Fee Schedule.

Added:

D & C with Radium	$75.00
Remove foreign body from eye	5.00
Emergency care for accidents up to	15.00

Increased:

Hysterectomy-cervix removed	$120.00 to $160.00
Cystoscopy	10.00 to 15.00

We would have liked more extensive liberalization, but the Plan's experience does not permit it at this time.

A Fee Schedule Committee of the Board has made recommendations to correct fees we know need adjusting. We are also obtaining information periodically from other prepaid plans on their fees and experience. As soon as conditions warrant, improvements will be made. One thing is certain: No plan can have both wide utilization and pay high fees.

In addition to several insurance companies which have inquired as to the possibility of underwriting the N.M.P.S. Plan, the New Mexico Hospital Association requested a meeting with a committee of New Mexico Physicians' Service.

Since relations between the two groups have been somewhat strained in the past, we are pleased to report that the meeting was harmonious. The Hospital Association group seemed as interested in finding a common ground as we were.

I quote from the Joint Report:

"The objectives of the meeting were stated as:

"1. Cooperation and understanding between medical and hospital associations in an effort to present to the public a unified program of prepayment insurance in medical and surgical contract, as well as hospitalization coverage. It was felt that in view of the trend toward compulsory medicine it was mandatory that such cooperation be obtained. The Joint Committee was to issue no publicity, but was to report to their own respective Boards for further information and direction.

"The Medical Committee asked two questions:

"1. A polled vote by hospital of those hospitals which voted at the recent Hospital Association meeting in support of the resolution endorsing Blue Cross as the only voluntary prepayment plan which could be endorsed.

"2. The Medical Committee also desires to know the names of the members of the Board of Trustees of the Blue Cross.

"The Medical Committee was asked to state the points of difference upon which a unified program could be formulated. These points are:

"1. The company offering the insurance must be regulated in the State of New Mexico.

"2. There must be assurance of financial soundness in continuing operation.

"3. The hospitals should not consider continuing to give preferential treatment to Blue Cross in granting a subsidy to the patient to the amount between what the Blue Cross pays and the hospital charges (if the hospital plan wants endorsement by the medical profession of a contract for professional services).

"4. The medical and surgical prepayment coverage should give the patient complete protection under the income levels as found in the present New Mexico Physicians' Service Medical and Surgical Contract.

"The Hospital Committee pointed out the differences between the service and indemnity type of contract, the fact that the Blue Cross Service concept is widespread, and this would have to be discussed with local and perhaps national authorities. (The Medical Committee has no objection to a service hospital contract provided the hospitals do not lose money on it and provided the same contract is offered to New Mexico Physicians' Service Plan.) (The Medical Committee felt that it would not be reasonable to endorse a service contract for professional service by Blue Cross if the latter had a preferential contract for hospital service. The Committee felt that it might be possible for Blue Cross and interested sound commercial insurance com-

panies who would qualify for endorsement by New Mexico Physicians' Service and Blue Cross to sell coverage on a competitive basis and to allow the premium to seek its own level.)

"The Hospital Committee feels that the medical and surgical contract of the Blue Cross should be reviewed and as a first step, to see if agreement can be reached on this point. At the same time, it feels that the payment by Blue Cross for hospital costs or charges should be reviewed. In this review it must be understood that hospitals have an equal responsibility to conduct uniform accounting so that the actuarial principles necessary in insurance can be adhered to.

"Since this was a committee meeting, no concrete recommendations are made, but it is suggested that the Board of Trustees of the Hospital Association meet at any early date with the Committee for a discussion as to the program from now on.

"Additions requested by the Medical Committee are bracketed."

The meeting was requested by the New Mexico Hospital Association and held October 8, 1950, yet over six months later no attempt in any form has been made, either by the New Mexico Hospital Association, or by the Blue Cross, to continue the discussion, or to answer our questions raised at that meeting.

It is encouraging to be able to report that from the patient's point of view, N.M.P.S. is more satisfactory than any plan they have ever had. There is no doubt that it has reached the position of playing an important part in our defense against government regimentation. Whatever degree of success N.M.P.S. has obtained is due to the excellent support that the overwhelming majority of the physicians are giving it as professional members.

There are a few physicians, particularly among recent arrivals to our state, who are not supporting N.M.P.S. When you go back home, I hope you will emphasize to them that your membership in N.M.P.S. means a sacrifice to you; a sacrifice that most of us are only too willing to make to retain freedom of our practice. Those who refuse to serve are just getting a free piggy-back ride at our expense. Some plans have solved the problem either by reducing by 50 per cent the fee paid to non-member physicians, or by refusing to make any allowance whatever to them. We can't be too concerned with those physicians who are shirking their responsibility to their colleagues and to the future of medicine. The American Medical Association emphasizes that the physician sponsored plans have emerged from the experimental stage. Leaders in our profession consider their success indispensable, very likely as the deciding factor, in guaranteeing our freedom. Physicians who are doing their part can look with satisfaction to the progress that has been made. Those who aren't doing anything may, for their own sake, as much as anyone else's, re-examine their position.

JOHN F. CONWAY, M.D., President.

Revision of By-Laws

At the meeting of the 1950 House of Delegates the President was instructed to appoint a committee to recommend a revision of Chapter I of the By-Laws on Membership. A committee composed of Dr. J. C. Sedgwick, Chairman, Las Cruces; Dr. G. A. Slusser, Silver City; Dr. W. J. Hossley, Deming, and Dr. W. B. Cantrell, Truth or Consequences, was appointed.

The following are the recommendations of the committee:

"Section 1. The name of a physician on the properly certified roster of members of a component society which has paid its annual assessment, and which requires each applicant to be a citizen of the United States of America; be of good moral character, a graduate of a medical school in good repute and a licensed practitioner of the state, shall be prima facie evidence of membership in this so-

ciety. Membership shall consist of the following classes:

"a. Regular Members. Regular members shall consist of members as certified above.

"b. Honorary Members. Honorary membership shall be conferred by the House of Delegates on recommendation of the Council for outstanding achievement in the field of medicine or outstanding service to the State Society. An appropriate certificate shall be presented to such members by the Society.

"c. Emeritus Members. Any regular or honorary member of the Society for five (5) or more years may, on application to the Society, be granted an emeritus membership by the House of Delegates on recommendation of the Council. Such membership shall entitle the holder to all the privileges of the Society without payment of dues. Such an emeritus membership shall be conferred only on those members who, because of illness, financial hardship, or retirement from active practice, are unable to pay the regular dues.

"d. Associate Members. Upon application and payment of a nominal fee of $10.00, medical officers of the Armed Services, Veterans and Public Health Administration, or State Institutions may be admitted to the Society as associate members. Such membership does not entitle the holder thereof to voting privileges of the Society."

Sections 2, 3 and 4 remain as written in the By-Laws.

JAMES C. SEDGWICK, M.D., Chairman.

New Mexico Advisory Committee to Selective Service

This committee has to date reviewed as to essentiality or availability a total of thirteen doctors. Of this total, nine were in Priority I, four were in Priority II. Of the nine in Priority I, seven were classified available, two were classified essential. Five of these cases were reviewed for Selective Service, three of these cases were reviewed for the Army, and one of these cases was reviewed for the Navy. Of the four in Priority II reviewed, all were for Selective Service. Three were classified available, one was classified essential.

Of those classified essential a temporary deferment for the purpose of securing replacement was recommended in one case; the other two essential classifications were based on the need of the community for the doctor under consideration.

There has been one case in which the recommendation of this committee has not been accepted without question. The case has been referred to Washington for final disposition.

Information of Interest: There have been six dentists and two veterinarian cases reviewed by the State Committee. Under the Doctor Draft Law there are a total of 214 doctors registered as of February 1, 1951:

	M.D.'s	Dentists	Veterinarians
Priority I	19	3	5
Priority II	7	6	1
Priority III	78	--	--
Priority IV	129	--	--
	214		

All registrants in Priority I and II have had physical examinations and essentiality or availability established. Initial physical examination of doctors by local draft facilities showed a 40 per cent rejection rate as compared with 13 per cent for dentists and 2.2 per cent for veterinarians. Trial examinations conducted by a three-day study period in an Army Hospital reduced the rejection rate to 23.4 per cent. This procedure is to be followed on re-examinations and doctors rejected for physical reasons in the future.

Notice has been received that in the near future x-ray, laboratory, dental technicians and nurses will be reviewed by this committee to establish availability or essentiality.

L. G. RICE, JR., M.D., Chairman.

WYOMING
State Medical Society

THE 20 PHYSICIANS IN WYOMING DELIVERING THE MOST BABIES DURING 1950

Edward W. Kunckel, Casper, 184; Ralph O. Shwen, Cheyenne, 181; Lowell D. Kattenhorn, Powell, 177; Bernard J. Sullivan, Laramie, 169; Everett L. Ellis, Cheyenne, 160; Arthur E. Prevedel, Rock Springs, 151; S. J. Giovale, Cheyenne, 136; Wilber Hart, Casper, 133; A. A. Engelman, Worland, 127; James W. Sampson, Sheridan, 117; E. W. McNamara, Rawlins, 112; L. B. Morgan, Torrington, 107; O. L. Treloar, Afton, 106; L. G. Booth, Sheridan, 105; F. H. Haigler, Casper, 104; R. B. Baker, Casper, 98; T. B. Croft, Lovell, 93; G. W. Koford, Cheyenne, 91; K. L. McShane, Cheyenne, 89; S. H. Worthen, Afton, 86.

WYOMING PUBLIC HEALTH ASSOCIATION ELECTS OFFICERS

Following Dr. Haven Emerson's talk in Casper, the Wyoming Public Health Association elected officers for the coming year. The new officers are: President, Mrs. B. B. Robertson, Lovell; Vice President, Dr. Albert Taylor, Cheyenne; Secretary, Ferne Fehlmann, Cheyenne; Treasurer, Jewell McAnally, Cheyenne; Executive Member, Dr. Paul Emerson, Cheyenne.

Auxiliary

The six County Auxiliary Presidents for the State of Wyoming are:

Goshen, County—Mrs. H. B. Rae, Torrington.

Northwest Wyoming—Mrs. J. H. Bridenbaugh, Powell.

Natrona County—Mrs. George Knapp, Casper.

Sweetwater County—Mrs. Jay G. Wanner, Rock Springs.

Sheridan County—Mrs. William Schunk, Sheridan.

Laramie County—Mrs. E. W. Newman, Cheyenne.

The Woman's Auxiliary to the Laramie County Medical Society celebrated its tenth birthday in May. This Auxiliary has grown

from nineteen charter members to a present memberhsip of forty-two. Eight wives of doctors at the Veterans' Hospital will join the group next year, bringing the memberhsip to fifty.

The first object of a Medical Auxiliary is to extend the aims of the medical profession to all organizations which look for advancement of health and health education. In connection with this aim, the Laramie County Auxiliary sponsored a breakfast at the Plains Hotel, April 29, 1951, in honor of Dr. Haven Emerson of New York City. Dr. Emerson is known internationally as the Dean of Public Health. Approximately seventy community leaders interested in community health heard his excellent speech on "Basic Health Services in Public Health."

Recently the Auxiliary presented two hampers for the delivery room to the Memorial Hospital in Cheyenne.

The Woman's Auxiliary to the Natrona County Medical Society has recently reorganized. At present they are helping to furnish the pediatrics ward at the hospital in Casper.

Mrs. Amy Lauzer died May 5, 1951, at her ranch home at Cora, following an illness of several months. Mrs. Lauzer was born Amy Geis in Saratoga, Wyoming. She took nurses' training at Wyoming General Hospital in Rock Springs and remained there as a nurse for some time. Later she served as superintendent of the hospital in Sheridan. She married Dr. Edward Lauzer about 1915. Mrs. Lauzer was a member of the Woman's Auxiliary in Sweetwater County.

MRS. FRANKLIN D. YODER,
Publicity Chairman.

PAN-PACIFIC SURGICAL CONGRESS

Dr. F. J. Pinkerton, President of the Pan-Pacific Surgical Association, reports that plans are well under way for the association's Fifth Congress.

Dates for the Honolulu Congress are November 7-19, 1951. The scientific program will begin on November 12 and continue through November 16 and will include sessions in all divisions of surgery, presented by topflight surgeons from the Pacific area countries. In addition to attending an outstanding surgical conference, doctors may enjoy a vacation in Hawaii and are urged to bring their families with them.

The Pan-Pacific Surgical Association has been officially appointed as travel agent for those attending the congress. Hotel and travel reservations may be made through the Association Office, Suite 7, Young Hotel Building, Honolulu, Hawaii.

A sanatorium must not be regarded as just a place where the patient has a bed and a tray and a nurse and a physician. A sanatorium, if it serves its purpose, is in the first place an atmosphere in which each patient is leading the kind of life he must lead for cure of tuberculosis.—Calif. Med., Edward W. Hayes, M.D., December, 1950.

UTAH
State Medical Association

Obituaries

FRANK D. SPENCER

Dr. Frank Daniel Spencer, 60, a physician and surgeon in Salt Lake City, Utah, for many years, died April 13, 1951, of a heart ailment.

Dr. Spencer received his Doctor of Medicine degree from Columbia University College of Physicians and Surgeons in 1918. He served his internship in Bellevue Hospital in New York, then was obstetrical resident at Manhattan Maternity Hospital and a surgical resident at Presbyterian Hospital in New York. He began his practice in Salt Lake City, with Dr. R. S. Allison, an association which continued until Dr. Spencer's death. He was on the surgical staff at the Salt Lake General Hospital for many years, and was a member of the staff of St. Mark's Hospital. He was President of the St. Mark's Hospital in 1946 and at the same time was a member of the Advisory Committee of the Hospital Board.

Dr. Spencer was a Fellow of the American College of Surgeons, a member of the Salt Lake County Medical Society, the Utah State Medical Association and the American Medical Association.

He is survived by his widow, Mrs. Ellen Cobb Spencer; a daughter, Mrs. John T. AuWerter of Cleveland, Ohio; a son, Richard H. Spencer of Hamden, Connecticut; one sister and a brother and six grandchildren.

SAMUEL G. PAUL

Dr. Samuel G. Paul, 74, a pioneer in Utah's public health program and Salt Lake City physician for many years, died February 20, 1951, following a lingering illness.

Dr. Paul served as Salt Lake City school physician for twenty-six years, retiring in late 1946. Known by several generations of school children, he had once estimated that he had examined at least 100,000 children of school and preschool age. Following his retirement he had served for three years as chairman of the Salt Lake County Board of Health.

Dr. Paul graduated from the Pennsylvania School of Medicine in 1901. He served for a time as Salt Lake City Health Commissioner and was instrumental in inaugurating numerous health programs. He was primarily responsible for instituting numerous reforms during his long years in public health work, such reforms including the first city milk ordinance, public milk stations and well-baby clinics, a public health nursing program, bacteriological examinations of water supplies, slaughterhouse and meat inspection, the establishment of an emergency hospital in the public safety building.

Dr. Paul was a member of the Salt Lake County Medical Society, the Utah State Medical Association and the American Medical Association.

Surviving Dr. Paul are his widow; a son, Samuel G. Paul, Jr.; two grandchildren, one brother and two sisters.

CLINT ALLEN LAFFOON

Dr. Clint Allen Laffoon, Park City physician and doctor for the Union Pacific Railroad and

the Silver King Coalition Mines here, died Thursday, May 10, 1951.

Dr. Laffoon was born November 23, 1880, in Kearney, Missouri, and came to Utah in 1926, settling at Kamas, where he practiced until 1942, when he moved to Park City, Utah.

Dr. Laffoon was a member of the Presbyterian Church, a life member of Doris Lodge, F. and A. M., Fairplay, Colorado; Park City Kiwanis Club; Mountain Chapter No. 2, Order of Eastern Star; American Association of Railroad Physicians and Surgeons; Utah State Medical Association; American Medical Association; Salt Lake County Medical Society, and a member of the Synod of Seniors, American Institute of Homeopathy.

Dr. Laffoon is survived by his widow; one son, Cyril Laffoon of Harlington, Texas; one grandchild, and a brother, Edgar Laffoon.

FIVE ATTEND NEW ORLEANS ASSEMBLY

The following Utah physicians registered at the Fourteenth Annual Meeting of the New Orleans Graduate Medical Assembly, held May 5 to 8: Lawrence N. Ossman, Ralph C. Pendleton, H. R. Reichman, Frank J. Winget and Spencer Wright. All are from Salt Lake City.

COLORADO
State Medical Society

ANNUAL SUMMER CLINICS OF CHILDREN'S HOSPITAL

Annual Summer Clinics of the Children's Hospital will be held on June 20, 21 and 22, 1951. The guest speakers are: Dr. Alexis F. Hartmann, Pediatrician, Washington University, St. Louis, Missouri; Dr. Herbert E. Coe, Pediatric Surgeon, Children's Hospital, Seattle, Washington; Dr. Douglas N. Buchanan, Pediatric Neurologist, University of Chicago, Chicago, Illinois.

Each guest speaker will conduct a two-hour clinic on one of the three days; give a lecture on a subject of general interest within his field; appear with staff members and guests in panel discussion of pertinent subject matter of common interest and concern to all physicians interested in the care of infants and children. In addition, the guest speakers and staff members will take part in a question-answer period following luncheon each of the three days. Further information concerning the clinics may be had, and registration for the clinics may be accomplished, by calling or writing to the chairman at the hospital.

Obituaries

HARRY L. BAUM

Dr. Harry L. Baum of Denver died at his home of a heart attack, at the age of 63, on March 24, 1951. He was prominent as a nose and throat specialist and had practiced in Denver since 1911. Dr. Baum was a national leader in his field; he did fundamental research in respiratory infections, contributed to continual progress in his field, and stood for aggressive research. His fine influence in the practice of medicine will be greatly missed.

Dr. Baum was born September 7, 1887, in Shelbyville, Illinois. He received his degree in medicine in 1910 from the University of Pennsylvania Medical School and started his practice in Denver in 1911. He was at one time chief of staff at both Children's and Presbyterian Hospitals in Denver. He was a diplomate of the American Board of Otolaryngology and was a member of the Colorado Otolaryngological Society, the American Academy of Ophthalmology and Otolaryngology, the American Broncho-Esophagological Association, the Denver County and the Colorado Medical Societies and the American Medical Association.

Dr. Baum was grand master of all Colorado Masons in 1938. He helped organize Emulation Lodge No. 154, A. F. and A. M., in 1921 and became its master the following year. He was a member of Colorado Consistory No. 1, Denver Chapter No. 2, Royal Arch, and was a Knight Templar. He was past sovereign of the Red Cross of Constantine. He had been chairman of the Correspondence Committee of the Grand Lodge of Colorado, A. F. and A. M., for the past thirteen years.

S. R. McKELVEY

Dr. Samuel R. McKelvey of Denver died April 10, 1951, at General Rose Hospital after a long period of illness. His death occurred just a few days previous to his ninetieth birthday.

Dr. McKelvey was born April 14, 1861, in Owen County, Indiana. He attended school in Indiana and was qualified as a teacher at the early age of 15. He earned his way through Western Reserve University by teaching and received his medical degree in 1884. He did postgraduate work at Johns Hopkins Medical School, Baltimore. While making his home in Indiana and following the practice of medicine, he also served as a representative and later as senator in the Indiana State Legislature.

In 1901, Dr. McKelvey moved to Denver. He was appointed a member of the Colorado State Board of Health in May, 1911, and became State Food and Drug Commissioner in 1917; he served six terms as Secretary of the State Board of Health. During this time he developed the first compilation of health laws and organized the department into various divisions. He retired in 1935. He was a Mason and a member of the Woodmen of the World, Knights of Pythias, the Denver Medical Society, Colorado State Medical Society, and the American Medical Association. Dr. McKelvey served his community in an efficient and loyal manner for many years and his loss will be greatly felt.

NOBUYA KUNITOMA

Dr. Nobuya Kunitoma of Denver died in April, 1951, at the age of 70, while on a visit to his native country of Japan. He will be missed by his many Colorado friends.

Dr. Kunitoma was born in Tsuchiura, Japan, where he received his preliminary education. After receiving a medical degree in 1901 he came to the United States for a postgraduate course in medicine. He was graduated from the University of Illinois in 1907 with a law degree,

and in 1912 he received an additional degree in medicine from the University of Pennsylvania. He had practiced medicine in Denver since 1912. He was on the staff of Mercy Hospital and was a member of the American Medical Association, the Denver Medical Society, and the Colorado State Medical Society.

During World War I, he was a First Lieutenant in the United States Army Medical Corps. He had a great interest in sports and was a member of the Old Timers Baseball Association. He was an honorary member of the Rainier Club, a Japanese organization in Denver. While living in the United States he spent much time trying to improve racial relations.

COLORADO
Medical School Notes

NEW LOAN FUND STARTED

Staff physicians and former interns of Denver General Hospital have recently established the V. R. Boynton Loan Fund to aid medical students, interns, and residents of the University of Colorado's teaching hospitals. The fund, honoring Dr. Boynton upon completion of twenty-five years' service as chief resident physician at Denver General, had reached $1,200.00 at May 1 and is reported growing rapidly. Contributions may be sent direct to the University of Colorado at Boulder, with a notation that this loan fund is to be credited with the gift.

Tuberculosis Abstracts

Issued Monthly by the National Tuberculosis Association

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DIAGNOSIS OF PULMONARY LESIONS DISCOVERED BY MASS ROENTGENOGRAPHIC SURVEY

PART II

Dumont Clark, M.D., Carl W. Tempel, M.D., and Kenneth D. A. Allen, M.D., The Journal of the American Medical Association, July 15, 1950.

Tuberculosis. A definite diagnosis of tuberculosis is not made clinically until the tubercle bacillus is found or the lesion is seen under the microscope. If the physician feels certain of the diagnosis without being able to find the tubercle bacillus, a tentative diagnosis is made. Since treatment of tuberculosis takes a long time, a positive diagnosis is most essential. Serofibrinous pleurisy with effusion should be considered tuberculous in origin. If lesions persist, atypical or virus pneumonia can be eliminated. Carcinoma, coccidioidomycosis, bronchiectasis, chronic lung abscess, bullous emphysema or cystic disease may involve the upper lobe of either lung and be confused with tuberculosis. An expert in pulmonary diseases should be consulted when a definite diagnosis cannot be made. All pulmonary lesions should be considered tuberculous until proved otherwise. A healed, usually calcified, primary tuberculous lesion in the lung, called a "Ghon" focus, is seldom serious, yet the assumption that any small pulmonary density in the roentgenogram can be viewed with complacency is erroneous. It is important to emphasize that most patients with early minimal tuberculosis are entirely symptom free, and yet

the lesions are active and potentially progressive. Often they are the forerunners of advanced and destructive tuberculosis.

Carcinoma. Active tuberculosis is found at all ages, but cancer is a disease largely of middle or old age. The suspicion of tuberculosis in chronic pulmonary lesions should not retard the diagnosis of carcinoma. Cytologic study, by experts, gives a quick and accurate diagnosis in 80 per cent or more of cases of bronchogenic carcinoma. If sputum is lacking, early bronchoscopy to obtain bronchial secretions and a biopsy specimen, if necessary, are indicated. Should these fail to establish a diagnosis in a person over 30 years of age, exploratory thoracotomy should be considered. The only worthwhile treatment of bronchogenic carcinoma is pneumonectomy. Palliation can be obtained in inoperable cases by adequate roentgen therapy.

Bronchiectasis. A history of repeated chest colds frequently complicated by pneumonia often with a persistent cough and hemoptysis suggest bronchiectasis. If no tubercle bacilli are found in the sputum, bronchoscopic examination and a bronchogram should be made. It may be difficult to differentiate bronchiectasis from chronic cystic disease.

Bullous Emphysema and Cystic Disease. Bullous emphysema and cystic disease (emphysematous bleb, pneumatocele, peripheral pulmonary cyst) exist either as a solitary large bulla or multiple smaller bullae which can be confused with ordinary pneumonia or, as the pneumonia subsides, with tuberculosis. The rupture of a single small surface bulla may cause spontaneous pneumothorax in an otherwise normal lung. Pulmonary cysts vary greatly in size and number. One that contains air stimulates a tuberculous cavity, or if filled wholly or partly with fluid, it may be confused with a chronic lung abscess, tuberculosis or encapsulated empyema. A cyst that refills with fluid after aspiration suggests the diagnosis.

Pneumoconiosis. Many industrial inhalants produce changes in the lungs detectable on the roentgenogram among which the most important is silica. In diagnosis, a history of exposure is the essential feature. The roentgenographic appearance of silicosis is more or less definite, although it must be differentiated from miliary tuberculosis, metastatic carcinoma which has spread through the pulmonary lymphatics, the fungus infections histoplasmosis and siderosis. The tubercle bacillus complicates most cases of silicosis. Roentgenographic signs of berylliosis, a newcomer among industrial inhalant diseases, are not as yet fully established.

Atypical Pneumonia. A few persons have atypical or virus pneumonia without acute symptoms. The roentgenographic appearance may then be confused with that of tuberculosis but frequent serial roentgenograms will help to establish the differential diagnosis. The presence of cold agglutinins is not specific but suggests the diagnosis.

Fungus Diseases. A person who has never been in the southwest portion of the United States will not have coccidioidomycosis. Histoplasmosis is most prevalent in a region extending from Kansas City, Kan., to the Atlantic Coast. A repeatedly negative reaction to a skin test with coccidioidin or histoplasmin rules out the respecive disease and a positive reaction with a negative tuberculin reaction is strong presumptive evidence that the pulmonary lesion is occidioidomycosis or histoplasmosis. The diagnosis may remain in doubt unless an exploratory thoracotomy seems indicated.

Chronic Suppurative Lung Diseases. Chronic lung abscess is usually a sequela of acute lung abscess and may be associated with chronic empyema. Physical examination of the lung and bronchoscopic and bronchographic examination usually establishes the diagnosis. The treatment of chronic lung abscess is excision, as a rule by lobectomy. The treatment of chronic empyema is surgical.

Nonspecific Pneumonitis. The roentgenographic appearance of chronic nonspecific pneumonitis may be confused with that of tuberculosis and carcinoma. Surgical exploration should be done when this lesion is suspected in adults.

Atelectasis. This is usually an acute process which disappears in a few weeks.

Fibrosis and Emphysema. Diffuse bilatral pulmonary fibrosis is seen in older persons. Pulmonary emphysema can develop if the lung is chronically over-distended or if the pulmonary blood supply is diminished. The roentgenograph shows increased radiability and flattened hemidiaphragm.

Sarcoidosis. Sarcoidosis is a systemic disease frequently involving the lymph nodes in the thoracic cavity and the lungs. There may be few or no symptoms. Biopsy of a superficial or intrathoracic lymph node establishes the diagnosis. Sarcoidosis is confused with tuberculosis, lymphoma, carcinoma, coccidioidomycosis and active histoplasmosis.

Lymphomas. The diagnosis of Hodgkin's disease is made by biopsy of an involved lymph node or exploratory thoracotomy.

Metastatic Neoplastic Disease. The usual roentgenographic appearance of a metastatic carcinoma in the chest is that of multiple small round or nodular lesions throughout the lung.

Leukemia and Collagen Diseases. Leukemia, polycythemia vera, and the collagen diseases—disseminated lupus and periarteritis nodosa—should be detected in the general examination.

Passive Congestion. Positive evidence of tuberculosis or carcinoma should be at hand when pulmonary circulatory congestive changes are possible.

Diaphragmatic Hernia. Diaphragmatic hernia should be suspected in any pulmonary lesion which is continuous with the diaphragm. A barium swallow, gastrointestinal roentgen study or, rarely, pneumoperitoneum will demonstrate the defect.

Benign Intrathoracic Tumors. Early benign tumors can be confused with other round lesions and should be removed. Any of them can undergo malignant degeneration.

The Book Corner

New Books Received

Nutrition and Alcoholism: By Roger J. Williams, University of Oklahoma Press, Norman. Price, $2.00.

Philosophy for the Common Man: By Heinrich F. Wolf, Philosophical Library, New York. Price, $3.50.

A Textbook of X-Ray Diagnosis: By British Authors, in four volumes. Second edition. Edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., Director, X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., F.C.R.P., F.F.R., D.M.R.E., Director, X-Ray Department, Westminster Hospital; Radiologist, Royal Chest Hospital, London. Volume 1 with 439 illustrations. W. B. Saunders Company, Philadelphia and London, 1951.

Clinical Heart Disease: By Samuel A. Levine, M.D., F.A.C.P., Clinical Professor of Medicine, Harvard Medical School; Physician, the Peter Bent Brigham Hospital, Boston; Consultant Cardiologist, Newton-Wellesley Hospital; Physician, New England Baptist Hospital. Fourth Edition, illustrated. W. B. Saunders Company, Philadelphia and London, 1951.

Handbook of Medical Management: By Milton Chatton, A.B., M.D., Instructor in Medicine, University of California Medical School, San Francisco;

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Sheldon Margen, A.B., M.D., Clinical Instructor in Medicine, University of California Medical School, San Francisco; Henry D. Brainerd, A.B., M.D., Assistant Clinical Professor of Medicine and Pediatrics, University of California Medical School, San Francisco; Assistant Clinical Professor of Pediatrics, Stanford University School of Medicine; Physician in Charge, Isolation Division, San Francisco Hospital. Second Edition. University Medical Publishers, Post Office Box 761, Palo Alto, California. Price, $3.00.

A Few Buttons Missing: The Case Book of a Psychiatrist: By James T. Fisher, M.D., and Lowell S. Hawley. J. B. Lippincott Company, Philadelphia and New York. Price, $3.50.

Electroencephalography in Clinical Practice: By Robert S. Schwab, M.D., Director of the Brain Wave Laboratory, Massachusetts General Hospital, and Associate in Neurology, Harvard Medical School. Illustrated. W. B. Saunders Company, Philadelphia, London, 1951. Price, $6.50.

Clinical Laboratory Methods: By W. E. Bray, B.A., M.D., Professor of Clinical Pathology, University of Virginia; Director of Clinical Laboratories, University of Virginia Hospital; with 119 text illustrations and 18 color plates. Fourth Edition. St. Louis: The C. V. Mosby Company, 1951. Price, $7.25.

COLORADO
State Health Department

A COMMUNITY MEDICAL PROBLEM—POLIOMYELITIS

The importance of poliomyelitis is increasing nationally. During the past three years, approximately 100,000 cases have been reported. A higher per cent of adults has been afflicted. In this age group, the mortality rate is three to four times that of early childhood. Improved medical treatment of the severely involved bulbar-respiratory patients has resulted in the survival of a large number of these greatly handicapped persons. The care and special rehabilitation of this group represent a very great problem.

From 1946 to 1950, the number of cases reported to the Colorado State Department of Public Health was as follows: 1946—900 cases; 1947—66 cases; 1948—126 cases; 1949—668 cases; 1950—205 cases.

For the first three months of 1951, 34 cases were reported to the Health Department. These cases were distributed as follows: Adams 1, Conejos 1, Costilla 4, Denver 3, Douglas 1, Jefferson 1, Larimer 13, Mesa 1, Montrose 4, Pueblo 4, Weld 1. The appearance of this rather unusual number of cases so early in the year, following a relatively low incidence in 1950, suggests the possibility of an epidemic outbreak in Colorado during the coming season. Therefore, constructive planning for patient care at this time is essential.

Decentralization of patient care is being emphasized in Colorado, as in many other areas of the United States. This means care of patients within, or near to, their local community. This approach is encouraged by the Disaster Commission of the Colorado State Medical Society.

Such a plan is predicated on the following rationale: 1. General hospitals can properly care for cases of acute poliomyelitis without fear of intra-mural contagion. 2. Transporting acutely ill patients for long distances decreases their recovery potential. A relationship between un-

usual stress during this period and severe disease has been repeatedly observed. 3. During periods of high case incidence, the maximum treatment capacity of the few hospitals which have previously cared for patients with this disease was impaired by overcrowding. This overcrowding also caused disruption of other medical services, and seriously dislocated teaching programs. 4. Separation of the patient from his family by long distances intensifies the general anxiety which often prevails in the community, and creates additional emotional problems for the patient.

Treatment has improved, but remains entirely symptomatic. Early bed rest, whether instituted at home or in the hospital, is of primary importance because activity can precipitate or intensify paralysis. Non-paralytic and mild cases can be satisfactorily managed at home if the physician is able to see the patient at frequent intervals and if the housing facilities are adequate. The attending physician can be assisted by local public health services (public health nurses, field physical therapists, sanitarians, etc.), in such a home-management program. Caring for mild cases in this manner allows more hospital service for the difficult diagnostic problems, more severely involved patients, and patients with inadequate home situations. For example, the Colorado General Hospital, which has cared for 28 per cent of all cases of poliomyelitis in the state for the past five years, wishes to reserve its facilities for: (1) the care of the acute and critically ill patients requiring special facilities not present in the community, and (2) the care and rehabilitation of paralytic cases from the outlying areas of the state, after the acute disease has subsided.

Generally speaking, mortality is not a good criterion of immediate accomplishments in tuberculosis control because the majority of deaths from this disease is the result of infections which occurred long before. Therefore, for many years after an excellent tuberculosis control program is instituted in a given community, mortality may remain high among those who were infected previously.—Journal-Lancet, J. Arthur Myers, M.D., April, 1950.

Index to Advertisers

Nutritional Status...

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1. Bortz, E. L.: Management of Elderly Patients. Postgraduate Med. 3:186 (Mar.) 1950.

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